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### EDITORIAL NOTES.

Most remarkable, in more ways than one or two, was the International Tuberculosis Congress held in Washington during the closing days of September and the early days of October. The daily press has had quite a little to say of it—particularly of those things which seemed to present some sensational features. But where is the publication that has uttered a single word concerning the most significant phase of the whole Congress? One of the very first speakers asserted, after due and careful study, that tuberculosis cost this country a billion dollars annually; that 138,000 persons died of this disease alone, each year. Now those 138,000 persons must have had some medical attendant and most of them must have paid no small sum to the medical profession during the course of the disease. Not a trifle, by any means. Furthermore, it is a matter of long observation that at least one person in ten has tuberculosis at some time in his life and probably that proportion of people, the world over, die of it. And yet, we see physicians from all parts of the world gather in Washington to the number of probably nearly 5,000 and there discuss enthusiastically the most recent discoveries and methods that will tend to stamp out the disease. The wonderful altruism of modern medicine passes recognition by the press. Can one imagine the Steel Trust devoting its energies to showing the people how to get along without steel? Can imag-

ination picture an aggregation of lawyers assembled to devise ways and methods by means of which litigation and the law's delays may be decreased? May one even picture an assemblage of clergymen perfecting a plan for universal salvation—without the necessity for supporting the churches? But the Tuberculosis Congress was the expression of the international effort of a single profession to cut off one-tenth of its income! In spite of which the people do not understand and are suspicious of our every effort. What is there about the medical profession that seems to put it so far beyond the understanding of the people that they will not see the truth? What is the matter with the editors of our lay publications, many of them men of remarkable intellect, that they fail to see the tremendous significance of such a gathering as the International Tuberculosis Congress? The assertion is made, apparently on good authority, that since 1880 the span of life has been increased six years. Has our profession, then, done nothing for humanity? And yet there are doubtless those who would say that the doctors keep 'em alive longer in order to treat 'em longer and so get more money! Ye Gods and little fishes!

At this time and distance it is not possible to review the very large amount of work accomplished at the Congress. Koch seems to have received a tremendous ovation, a reception only a trifle less marked having been

extended to the other luminosities of the tuberculous heavens. Battle seems to have raged over the much-fought question of the identity or dissimilarity of human and bovine tuberculosis, with, apparently, the same old result—a difference of opinion. Great interest was evidently manifested in the newer diagnostic aids, the conjunctival and skin reactions, and doubtless in a short time we shall have items of great interest on these subjects presented for our consideration. The attendance was much larger than had been anticipated, some reports placing it at not less than 5,000. Our own State was well represented, some fifteen or twenty of our members having been present. One thing is certain; there is no more doubt as to the great interest in and value of these international congresses.

If one takes a dispassionate birdseye view of certain present conditions in American medical life, he will receive a distinct shock. Let us assume—and the assumption will be near enough the fact—that there are in the United States 125,000 physicians and 250 medical journals. All of these journals are, supposedly, published for the benefit and in the interest of physicians. Hovering hungrily on the flanks of this band of 125,000 physicians, ninety-nine and a fraction per cent of whom are in no sense of the word business men—rather the reverse—we may observe another band, not of the medical profession (except in rare instances) but

IS IT  
DOLLARS?

living on it; these are they who make things which the physicians are to use in carrying out the daily work of their profession. Isolated, alone, conspicuously open to unfair attack, we note a small, a pitifully small, group of men who courageously stand between these two bands—the unbusinesslike professional men and the shrewdly businesslike ones who live by and upon them. This little group of unprejudiced scientific men say, in effect, to the manufacturer who wishes physicians to use his product: "What is this which you wish physicians to use? You know that of the 125,000 physicians in this country, at least 100,000 are too busy or too credulous to look into the truth of what you say about your product. We stand here for them and we wish to investigate your article and your statements so that you may not impose upon them; all that we ask is that you shall tell us, and through us the medical profession of the United States, the exact truth, that so lives may not be placed in jeopardy." All of which seems the acme of simplicity and one would imagine that, reasoning *a priori*, every one of the 125,000 physicians would cry out for joy and every one of the 250 medical journals would give hearty and sincere editorial endorsement of a policy that would so greatly help those in whose interests their publications are supposedly issued. But what are the facts? Alas! Of the 250 journals all but possibly 25 have attacked this effort to eliminate dishonesty and fiction, either positively and openly or negatively and secretly. Why? Can it possibly be that those who control these medical journals are blind to the truth of the exposures of frauds that have been revealed? Can it possibly be that they hold the prejudiced statement of the interested party of more value than the unbiased statement of a group of trained scientific men who have no ulterior object to accomplish? It would be absurd to credit them with such stupidity. There seems to be one only influence of sufficient weight and power to make men cast aside what they must know in their hearts is the truth and abide with what they must know is false and dishonorable—the almighty dollar. That which man will not do for wealth, has yet to be discovered. How long medical men will continue actively to perpetrate fraud on their fellows after their sin has found them out, no man can say; that they are now doing it, a dispassionate observation by any one will show. Truly, the present condition of the medical profession of the United States is anomalous in the extreme. And some organizations of medical men are no less anxious to be influenced toward the wrong than are single units, when it comes to taking the unsound and dishonestly earned dollars of the unscrupulous manufacturer. That is the pity of it.

When a real nice lady-like old party slaps you on the bare wrist and says, "There, now! You be good!"—aint it awful? When you're doing something you feel sure is right; AINT IT AWFUL! when you're making a fight that you know is right; when you see the opposition to such a fight and know just exactly what

inspires it and how rotten with debased and debasing commercialism the inspiration of the opposition is, is it not too bad to be chidden? It is, indeed it is. The management of your JOURNAL is in tears; it is going about in sack cloth and ashes; its wails may be heard resounding through the night and disturbing even the cat; for your JOURNAL has been scolded—slapped on the bare wrist! We had the temerity to say that those firms whose preparations we use should advertise in our JOURNAL and thus help along the fight for decency by aiding in its support. We went further and said that other things being equal we should use the goods manufactured by those who do advertise with us in preference to those of firms who do not aid us. That seemed a perfectly fair proposition and we have asked—and received—the support of a large number of our members on that as a platform. Furthermore, we have asked our members always to demand of the detail man, when he first enters the office, an answer to the question, "Does your house advertise in our JOURNAL? and if not, why?" Secondly, "Is your stuff approved by the Council? and if not, why?" These are simple things, but we think they are just and right. The *Medical World*, of Philadelphia, however, thinks this is perfectly dreadful! We should be ashamed! We are quite naughty! We are to be chid! We have been slapped on the wrist! "Aint it rotten Rosie?"

That pestiferous publication, *N. A. R. D. Notes*, a small sheet representing the purely commercial side of pharmacy and one which some time ago urged druggists to "push" ABSURD. peruna and any other old patent medicine that offered a certain possible profit, has recently come out with another startling suggestion. From the issue of September 17th we quote the following:

"There is no necessity for the doctor to dispense except in cases of emergency, and when he quits it his druggist should be punished if he doesn't quit counter prescribing," says an anonymous writer, and he is right, as far as he goes. But two wrongs never make a right. Is a druggist justified in counter prescribing because the doctor dispenses? There are decidedly two ways of looking at this question."

Was there ever a more pernicious suggestion! To encourage pharmacists in the illegal practice of medicine! And this from a publication representing the National Association of Retail Druggists. Can it be that that represents the attitude of any considerable number of pharmacists? We most sincerely trust that it does not. The duty of the physician is plain. It is his to relieve, if possible, the patient who calls upon him for professional assistance. Whether this relief shall come from an operation, from suggestion, from advice, from regulation of habit and diet, from baths, from drugs administered by the physician at the time, or given to the patient by the physician or prepared for the patient by the druggist upon the written order of the physician, are all immaterial questions; the one

essential thing is that the physician gives of his best for the relief of the patient. And now comes the druggist and says that the physician must confine his medicinal treatment of a patient to such things as are ordered through and prepared by the druggist. And further, that he, the untrained druggist without medical knowledge has the right to prescribe over the counter for the sick! No wonder that the N. A. R. D. is in sad straits; no wonder that it is discussing reorganization and such things in order to try and keep itself alive. If all the advice which this sheet has sent to its readers is of the same stripe as the morsel under discussion, its readers must have been urged to many illegal acts and must have been led into a good deal of trouble. This is pretty close to the acme of impertinence.

Comparatively recently two new hospitals have opened in San Francisco; both have been created

#### WHAT A DIFFERENCE.

from the medical profession, but in ways that differ as the day from night. Doubtless none save those who bore the burden can know the work and the strain and the personal sacrifices of the few men who unselfishly wrought, out of nothing, the University of California Hospital. First a body of laymen—the Regents—had to be convinced that the modern method of teaching medicine requires a hospital with patients in it. The underlying and cognate sciences may be taught wherever there are good teachers and laboratory facilities; but medicine and surgery must be taught at the bedside and in the operating room. Next, the Regents convinced, probably reluctantly, the hospital itself had to be erected from practically nothing. A building was secured by transferring all the preliminary work to the departments at Berkeley, thus freeing the medical building at the Affiliated Colleges, which was then to be transformed into a hospital. Funds for the transformation were obtained from and by the faculty of the Medical School, and it was soon found that the building adapted itself to hospital purposes remarkably well; better, in fact, than had at first been imagined would be the case. A clear-cut illustration of the altruism of our profession, this giving by the faculty of their time, their work, their brains and their money for what could profit them nothing, but for what they knew to be right. Now consider the newly opened German Hospital; a magnificent building equipped from top to bottom with everything that a hospital should have—and remember that every stick and stone of it, every least or greatest thing in it, has been paid for by money taken from the pockets of the physicians of California. The German Hospital stands a monument to commercialism and greed and professional prostitution. The German General Benevolent Society, starting right and working for the good of the sick or destitute German poor, long since became one of the worst "dollar a month," medicine at "bargain counter rates" institutions in the United States. The list of the well to do, the rich and the very rich who, for their paltry dollar

a month, have taken advantage of what originated for the aid of the poor, would make a startling showing. The reasonable and honest fees which these dollar-a-month patrons of the German Hospital should have paid to the various physicians of our state, have gone to the building of the German Hospital.

The last regular meeting of the San Joaquin County Medical Society was a notable gathering.

The subject for discussion was "The NOTABLE Proprietary Evil" and it attracted MEETING. the attention of the members to a marked degree. Elsewhere, the

JOURNAL prints a letter that was sent to every member and a list of questions which was enclosed with the letter. This whole question is one of common sense. Are we, as a profession, to go ignorantly on our way, fooled and lied to by the manufacturer either in regard to the composition of his stuff or as to the wonderfully impossible things it will do? Are we forever to shirk a goodly portion of our duty and disregard the composition of the things we put into our patients? That we can not believe the statements of any single manufacturer in the United States, has been conclusively demonstrated by the revelations of the Council on Pharmacy and Chemistry. We can not believe the manufacturer, for he wants to sell as much of his stuff as possible. We can safely rely upon the dicta of the Council, for they have no motive save to extract the truth—generally painfully and unwillingly—from the manufacturer. The crux of the whole matter is in the one thing—accept nothing that has not been approved by the Council, unless it be the well known articles in the U. S. P. or National Formulary. The Lord knows there are enough drugs available in those three lists! It would be a very good thing for every County Society in the state to devote one or more evenings to a discussion of this question so that every member could come to a clear understanding of what it means and the harm he is doing by not following the rule to accept nothing not approved by the Council. Of course all the "published-for-profit" medical (?) journals put up a howl at the mere suggestion of this (because they derive their profits from the advertisements of things which the Council has turned down) and they say a lot about using your own judgment; being independent; throwing off the yoke, and trash of that sort that seems to please them. Your own judgment is not worth a tinker's dam. Your "independence" is merely playing into the hands of the commercial manufacturer. There is no yoke except the yoke of lies that the unscrupulous exploiters have forged and placed upon our necks. Are you a chemist to analyze the stuff put before you and know whether the composition is as claimed? Of course not. Have you the time, the opportunity or the knowledge to investigate the claims made and determine whether or not they are true? Of course not. Then what is it to be? Are you going to place more faith in the manufacturers' statements than in the findings of a scientific body like the Council? Don't be foolish. Wake up!



That it is not well to pose as a prophet, particularly in one's own country, is an observation as old as recorded history. It is not surprising, therefore, that we do not see the scientific departments of our government uttering prophecies, save as they may be deduced by him who reads from the dry-as-dust compilations of mere facts or figures occasionally issued. From the Public Health and Marine Hospital Service comes a pamphlet of figures and bald statements of fact pregnant with the soul of prophesy.\*

In 1894 plague escaped from the endemic Indo-Chinese focus in the province of Yunnan, China, and infected Canton and Hongkong. Six years later, in 1900, it had invaded 76 different places in 26 countries, and in 40 of these it was noted as epidemic. By the end of the next 7 years it had invaded 146 places in 48 countries and in 76 of these it was noted as epidemic. Since January of the present year it has appeared in a number of other places, and in our own country, Los Angeles is to be added to the list of points where the pest has appeared. In 14 years it has spread to every continent on the globe and is there fixed in spite of, in many cases, every effort that modern science and unlimited money could combinedly put forth to uproot it. These facts are intensely significant and that the disease will still further increase and spread, is a prophesy almost elemental. As yet we do not know of the existence of plague in our Eastern or Southern seaboard, yet a careful examination of the rat population has not been made and one may well be justified in looking forward to such an examination with a certain amount of dread of the story that might be revealed. Quarantine measures along this entire seaboard have been directed practically exclusively to the maintenance of careful watchfulness for human plague, and the rodent, the real menace, seems not to have been under surveillance. With a vermin-free individual infected with plague, there is practically no danger of transmission of the disease, for the pneumonic form is so scarce as to be negligible. Only in a vermin-ridden population is the human agency in transmission one to be considered. If we have learned nothing else from the recent work of the Indian Plague Commission, and the still more recent work in San Francisco, we have learned the true nature of the disease and its transmission and that all quarantine measures should be formulated and carried out with the single idea of rat quarantine and vermin destruction. It is high time, in view of the exceedingly rapid distribution of the plague over the world, and of the facts which have been demonstrated in the last few years' work, that our federal government

extended its energies to a rat examination of the East and South, and that every seaport in that territory prosecute an active and reliable rat quarantine. No seaport in the world is without danger, for into any seaport a ship may come, and all ships carry rats some of which may have had the disease, in its quiescent, chronic form, for long periods of time. No other known disease offers so many curious variations in its epidemiology or is so terribly destructive of human life at one time and so insignificant in its ravages at others, without seeming rhyme or reason. There may be a quiescent period of years followed suddenly and inexplicably by a terrific epidemic. Fortunately, in spite of all that we do not know about the disease, the little that we do know serves to point out the road to protection. The handwriting is on the wall; shall we read it or complacently ignore it?

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What is to be the attitude of the medical profession, now fast learning the various ways in which it has been exploited and buncoed by the commercial manufacturer, toward the supposedly reputable pharmaceutical manufacturing house that voluntarily and intentionally goes into the patent medicine business? Shall we say that it is no concern of ours? Shall we quietly allow such a house to "play both ends against the middle?" Shall we aid the wanderer from the paths of plain and simple pharmaceutical manufacturing? That such questions are even now presenting themselves may be known to any one who uses his eyes to see and his mind to think with. For years we have looked upon the house of Frederick Stearns & Co. as one of the few really reputable and desire-to-be-decent pharmaceutical houses. And yet what is this house doing? Going straight into the "patent medicine" business direct and shamelessly. In innumerable places one may see "SHAC"—or Stearns Head Ache Cure—advertised to the laity. In street cars, displays in windows, etc., etc. This so-called headache "cure" is nothing more nor less than an acetanilide mixture and, according to the *Journal A. M. A.*, at least two cases of poisoning are chargeable to it. The same house is also going to the public with "Pam" for the dyspeptic and "Zymole Trokeys" for husky throats. What will it put out next? Is this the right sort of thing for a manufacturer, appealing to the medical profession for support, to do? It does not seem to be quite right, does it? There are some signs of an approaching condition of things in the medical profession when its members will say to the manufacturer, deal with us or the public, but not with both. Why not help that condition of things to approach? Why not assume that attitude toward Stearns? Is the house of Frederick Stearns & Co. in business to supply medicines for physicians or to treat the sick directly and illegally?

\* The Present Pandemic of Plague. By Asst. Surg.-Gen. J. M. Eager.



## CANCER OF THE UTERUS. HOW MAY WE SECURE ITS EARLIER RECOGNITION?\*

By W. FRANCIS B. WAKEFIELD, M. D., San Francisco.

Of all problems which confront the gynecologist this is the most important. It is one of the two most urgent surgical questions of the day; the necessity for earlier recognition of cancer of the stomach being the other. In both of them, to await the appearance of classical symptoms puts the patient practically beyond the pale of surgical remedy.

Whatever may be the true etiology of cancer, one fact is clearly demonstrable, and that is that chronic inflammatory induration is the most common exciting cause. It, therefore, is our duty to remove all chronic indurations in and about the uterus whenever such are discovered.

The uterus, particularly the vaginal portion of the cervix, is subjected to frequent trauma, and is, therefore, the common seat of inflammatory induration, which may, later, excite the epithelial cells to carcinomatous proliferation. It is of the very utmost importance, then, that traumatic lesions in the cervix, of sufficient severity to have produced chronic inflammatory surroundings, should receive appropriate surgical treatment. Here we are much handicapped by the fact that such lesions give rise to comparatively few symptoms. It is true that the chronic endocervicitis will give rise to leucorrheal discharge, but most women, and many physicians, regard leucorrhea as an unimportant discomfort that belongs naturally to women and with which they must simply put up. It is also true that the subinvolution of the uterus, which usually accompanies traumatic injuries to the cervix with their inflammatory results, will create local pelvic discomfort and general nervous manifestations, but here, again, the general opinion exists that these are natural penalties consequent upon motherhood. The result is, usually, nothing is done to relieve these local lesions which, though simple in themselves, are of most serious significance when considered in the light of their possible etiological connection with cancer of the uterus.

Even when cancer actually exists, it is often slow in producing any symptoms, and practically never produces the chain of so-called classical symptoms, viz., hemorrhage, malodorous discharge and pain, until it has developed beyond the reach of surgery as a possible curative agent. Speaking broadly, it may be said that hemorrhage is the only symptom present in the early stage of the disease; in the stage where radical surgery offers something. When a fetid discharge becomes a prominent symptom, considerable disintegration of tissue has taken place, the disease has, in all probability, progressed beyond the confines of the uterus, and surgical results are notoriously problematic. Pain, the direct result of the carcinomatous growth, is rarely ever present during the time when surgery can offer more than palliative results. If pain is present early in connection with

carcinoma of the uterus, it is due to coexistent tubo-ovarian inflammation. Therefore, if we hope to offer thorough surgery, any material future to women afflicted with cancer of the uterus, we must do so at the time when some abnormal bleeding is the sole symptom, or, still better, before there is any manifest symptom directly due to the carcinomatous process.

In view of all that has been written during late years on the subject, it should be unnecessary to point out to the physician the importance of thoroughly investigating an excessive bleeding at or about the menopause. That it is necessary, however, is evidenced by the fact that women are constantly presenting themselves to the gynecologist with inoperable cancer, who give a history of having had irregular hemorrhages for months, concerning which they have consulted their family physician, who never made an examination, but relieved their mind with the assurance that such symptoms were frequently associated with the menopause, through which they were probably passing. When will the rank and file of the profession learn that excessive bleeding is never a symptom of the normal menopause; that it always is evidence of some pathologic condition; and that, in the vast majority of cases, it means cancer of the uterus?

Occasionally opportunity presents itself to discover the existence of cancer of the cervix before it is evidenced by any symptom, and we are astounded at the progress the disease may make even before it produces any bleeding. I have recently had a chance to study such a case. This patient came to be treated for mechanical faults resulting from injuries during childbirth. Among other things, the cervix was bilaterally lacerated, was the seat of chronic inflammatory changes, and presented on the middle of the anterior lip a small, sessile, papillary outgrowth about two centimeters in breadth and one centimeter in thickness. Clinically, the growth seemed to be a very localized affair, with very little induration in its immediate vicinity, and no palpable induration of the surrounding cervical or vaginal tissues. A small piece was excised for histologic study and proved, on examination, to be a squamous-celled carcinoma. Sections made through the entire length of the cervix, subsequent to removal of the uterus, showed the large lymph spaces just above the cervico-vaginal junction to be filled with squamous-celled masses. This is the point where the lymph radicals coalesce to form the main lymph trunks that pass out to the parametrium; and who can say that carcinoma cells were not carried beyond the confines of the cervix even at this early stage?

Cases studied thus early impress upon us the necessity for very early diagnosis if we are materially to prevent the present woefully large number of recurrences and save the lives of the thousands of women who die annually as the result of cancer of the uterus in this and in every other populous country.

The following suggestions are offered in the hope

\*Read at the Thirty-Eighth Annual Meeting of the State Society, Coronado, April, 1908.

that they may lead to practical results which will be evidenced by the fact that the gynecologist and surgeon will see, in the future, a much larger percentage of cases sufficiently early to make surgical results promising:

1. Every woman should be examined by her accoucheur, after uterine involution has taken place, to ascertain if any material injury to the cervix has resulted from the labor; and if material injury is found, the cervix should either be repaired at once, or the patient required to present herself for examination once or twice a year, so that repair may be advised before the patient's future is menaced, should chronic inflammatory changes supervene.

2. All Chronic lacerations of the cervix with concomitant inflammatory sequelæ should be repaired at once; all chronic inflammations of the cervical or corporeal mucous membrane should receive appropriate treatment; all interstitial or sub-mucous tumors of the uterus should be removed.

3. Physicians should keep themselves constantly mindful of their responsibility in the matter. A small piece of tissue should be excised from any suspicious-looking patch on the cervix and subjected to histologic study, even though no symptoms pointing to cancer are present. All abnormal hemorrhages should be thoroughly investigated and, if no cause is evident on ordinary examination, the uterine cavity should be thoroughly curetted and serial sections made of the pieces of mucous membrane thus obtained, in an effort to prove or disprove the presence of adeno-carcinoma of the body or upper cervical canal.

4. Women should be educated to understand that danger attends the neglect of cervical injuries and chronic uterine inflammations; that every woman who has borne children may have such injury or such inflammation; that it would be wise for all women thus informed to ascertain from some competent physician whether any pelvic condition exists that would menace her future. Indeed, women would subserve their own best interests if they would make annual or semi-annual visits to some good, wise doctor, as a prophylactic measure, during the cancer period.

5. Women must be taught that excessive bleeding is never a coincident of the normal menopause, but is a symptom of great import, which should be immediately investigated.

6. A cancer committee should be appointed by the presidents of our different State Medical Societies, the duty of which will be to study the question generally and to evolve the best means of keeping the profession in touch with the subject and furthering, in some dignified and practical way, the dissemination of such knowledge as should be possessed by intelligent women.

On the family physician a great responsibility rests. Through him, in great measure, must women receive education on vital subjects. To him must largely be entrusted the future remedy for the

present woeful disregard of conditions which may be fraught with serious future menace to life. Should he awaken to the full sense of his public obligations and rise to the limit of his exceptional opportunities, a new era, full of promise, will dawn upon the cancer problem.

## INDICATIONS FOR MASTOID OPERATION.\*

By D. H. TROWBRIDGE, M. D., Fresno.

The general public, and I fear some physicians, look upon a suppurative ear as a matter of small importance. Some people think that the ichorous discharge from the ear is even of benefit to the system by draining out impurities from the blood. I might say in passing that this discharge as you all know is only an indication of the disease inside, and in itself is of as much benefit to the general system as a long distance Christian Science treatment would be. Of course if the cause for pus formation exists, it is better that it come out than that it be confined. The fact that there is a discharge merely indicates some diseased condition of the middle ear.

I shall divide this paper into two parts, the indications for operation in acute mastoiditis and the indications for operation in chronic mastoiditis or chronic suppuration of the ear.

The acute cases are the ones we are most frequently called upon to treat, although the chronic cases should be more often operated upon, in my estimation, than they are.

I formerly imagined, and I presume that others have the same opinion, that there was no reason or symptom for opening up the mastoid until there was redness and swelling behind the ear, usually with more or less temperature. Now this is just the point I want to emphasize; the indication for operation on acute mastoiditis is pain. There may be no swelling, no redness, and in fact no temperature, and yet if there is continuous pain on pressure over the mastoid antrum, accompanied by a discharge of pus from the ear, the case is ripe for operation. I do not say that every case that has pain behind the ear on pressure over the mastoid antrum, will not get well without operation, but I do say that by waiting and trusting to hot compresses and ice-bags, we are losing valuable time and oftentimes a life may be sacrificed by this kind of expectant treatment.

When a patient comes to me with considerable pain back of the ear, following a middle ear abscess that does not yield to local treatment readily and quickly, I advise an operation, for the operation is almost free of danger, and delay in liberating confined pus in this region is certainly fraught with great danger.

I believe in making a free opening of the mastoid bone and removing every portion of the diseased process, no matter how extensive the necrosis may

\*Read before the San Joaquin Valley Medical Society.

be. Should any diseased bone tissue be left, you are sure to have trouble, a prolonged convalescence, and more or less temperature. After a thorough mastoid operation, when all diseased bone is thoroughly removed, the temperature, if any, will drop to normal and remain there. To illustrate the necessity of an early operation I will cite a few cases:

Mr. R—, referred to me by Dr. J. L. Butin of Madera, a large muscular man. Examination revealed perforated ear drum, with a discharge of pus from it. He had no pain over the mastoid at this time; at the second visit, a week or two later, on pressure over the mastoid antrum, I found at this time some pain. There was no swelling, no redness, and it was only by moderately hard pressure that there was much pain. None of the most marked signs of suppurative mastoiditis were present, but upon opening the mastoid, I found a very extensive necrosis of the bony structure, in fact involving the entire mastoid bone. The lateral sinus was exposed and found covered on the outside with granulations, the necrosis extending down to the dura. He made a rapid recovery. This case was followed by one almost exactly similar a week later from Le Grand, sent me by Dr. McMaster.

Here are two cases with no fever, redness or swelling over the mastoid bone and in which they were walking around attending to their work and yet with a most extensive and dangerous disease of the mastoid, showing that redness, swelling and fever are not necessary to a diagnosis of disease in the mastoid cells.

These two cases just cited had had a discharging ear for only two or three weeks. I now wish to call your attention to another class of cases more acute and rapid in their course.

A baby fifteen months old, sent to me from Hanford by Dr. Toner. Child had had suppurating ear for one month, suddenly showed slight swelling back of ear with very little redness, and there had been for two or three days previous, severe pain, but on appearance of swelling, pain most all ceased. (This relief of pain was due to the abscess perforating through the external bony wall, thus relieving the pressure.) On opening up the mastoid, I found a large abscess cavity in the body of the mastoid bone, which was thoroughly curetted out. The little patient made a quick and uneventful recovery.

Son of Mr. W—, sent to me by Dr. Rosson of Hanford, had been suffering with discharging ear for only four days, had never had trouble with ear previously. There was no swelling over mastoid, nor redness, but severe pain increased by pressure over the mastoid antrum was present. I advised immediate operation and operated the same evening he came in, notwithstanding the fact that the ear had been discharging for but three or four days. I found a large pus cavity in the mastoid bone. After thoroughly removing all diseased bone, he was put to bed and made an uninterrupted recovery. This case shows how rapidly the bone tissue of the mastoid may become diseased.

The main points that I desired to bring out in this short paper are, the fact that the disease of the mastoid bone may progress very rapidly, that redness and swelling are not the most important symptoms, but that pain, especially over the region of the mastoid antrum, is the most important symptom and that by an early operation much destruction of tissue and danger may be prevented.

If you will bear with me I will speak just a few words about the radical mastoid operation. I had

the pleasure of witnessing a great many of these in Prof. Politzer's Clinic in Vienna. It consists of removing practically all of the mastoid bone including the posterior wall of the auditory canal, and the ossicles. Then the posterior membranous wall of the auditory canal is made into a flap and the wound back of the ear is closed, the dressings forcing the flap back against the denuded bone, covering it, and the dressing being done through the external auditory meatus. The operation is a modified Stake operation.

This operation is done in chronic cases of suppurative ear disease, and in about 50 or 60 per cent of cases, cures the discharge altogether and certainly removes much of the danger attending a chronic suppurative process in the middle ear in all cases. There is some danger in doing this operation of injuring the facial nerve which should be carefully avoided. The chronic suppuration of the ears is, as I mentioned above, thought by many to be of no particular danger to the patient, but during the past year four deaths due to extension of the inflammation from the ear to the brain have come under my observation. The importance of this is well known by the old line insurance companies who will not accept as a risk an applicant having a discharging ear. I do not claim that every case of chronic suppurative ear trouble should be operated upon, but I do know that most of them would be much safer were it done. Private cases I find are hard to convince of the importance of having this done. But in the clinics of our large cities of this country and Europe, it is more commonly performed than the operation for the acute mastoid cases.

### THE PURE MILK PROBLEM\*

By GEORGE H. KRESS, M. D., Los Angeles.

The Chairman of the Pure Food Committee indicated in his report, some of the work undertaken at Los Angeles in the effort to secure a supply of pure milk.

The great value of milk as a food to infants and invalids makes it desirable to discuss the subject at greater length in this symposium. To tell the members of this Society that hundreds of lives are annually lost because of dirty milk is to state nothing new. And yet so long as the medical profession allows dirty and dangerous milk to be sold to those who do not know its menace to the health and life of loved ones, just so long should medical men be reminded of their negligence and responsibility in this most important problem.

I believe it may be safely stated that if medical men did their full part to educate the lay people concerning the danger involved in the use of dirty milk, that it would only be a short time before the use of such milk would be done away with. The laity does not consume dirty milk because it prefers

\* Read as part of a Pure Food Symposium at the Thirty-eighth Annual Meeting of the State Society at Coronado, April, 1908.



it. It drinks it and allows infants and invalids to drink it, because it does not realize the danger therein, the medical profession not having done its full part in educating the laity in regard to this matter.

I believe that if we act unitedly, we can secure clean and safe milk for every city of California within five years. For what can be done in one place can be duplicated elsewhere, if the right forces are brought into action. Through our Pure Food Committees, (or better), Public Health Committees, as we hope to have them called, we possess the means whereby these ends may be attained. Place men who will work on your local public health committees, and they will be able to inaugurate a pure milk campaign in your county, without an over-great amount of effort.

There are two phases of the subject which we wish to briefly consider to-day:—certified milk and inspected milk.

By certified milk is meant milk from a healthy and tuberculin-tested herd gathered under such conditions as to keep the bacterial count down to a minimum so low as to indicate that the hygienic and sanitary conditions of the entire establishment are absolutely first class. In our certified dairy at Los Angeles the bacterial content must be less than 20,000 colonies to the cubic centimeter, but we hope to lower this in the future.

It is not possible in this brief talk to enumerate the many items which are necessary to attention by the dairyman, if he wants to produce a certified milk of known chemical and bacterial standard. The score cards which have been passed among you, give an idea of the factors to be considered.

It is most important that we should have milk of the certified standards, because infants and invalids should be given no other. Its extra cost, however, will prevent its universal use.

What is needed, therefore, above everything else is a safe milk, produceable at about the present prices and approximating as closely as possible, a certified milk standard. In other words, an inspected milk, so-called. By inspected milk is meant a milk inspected by city, or preferably, state officials, and conforming to the proper chemical standards as well as having a comparatively low bacterial count, say of 100,000 colonies to the cubic centimetre, instead of 500,000 or a million or millions, as is usually the case. Such a milk can be obtained, I believe, if we have a healthy herd and sterilized utensils.

The milk industry, so far as distribution to the consumer is concerned, has already fallen under the control of a few large dealers, and their creamery or collecting establishments are fitted with the steam and apparatus needed for sterilizing cans, bottles and other utensils. If we teach the small dairyman how to keep a well ventilated and clean barn, and clean corrals, and then instruct him to have the udders of the cattle and the hands of the milkers clean before milking, it will be possible to secure a pure and untainted milk from the cows and receive

the same into the previously sterilized cans without an over-great amount of contamination.

In other words, if this method could be put in vogue, it would be possible for us to obtain for the entire state of California, a milk almost equal in standard to a certified milk. All that is necessary is that we set about our task in the right way and show the large dealers and small dairymen alike, how this end may be obtained without much extra work and in the end, with more money profit to themselves.

But to obtain a milk of such standard inspectors are necessary, and a system of scoring dairies is necessary. The score cards which I have passed around are different from those shown last year. One year's experience with last year's form showed its typographical make-up to work against it, because the ordinary inspector was not able to comprehend and apply its suggestions.

To overcome this I devised with Dr. Powers, a form which, while occupying more space and more paper, is, however, so simply arranged that we believe that any ordinary inspector should be able to mark a dairy without much trouble.

The scheme is, I think, self-explanatory. The Pure Food Commission will take this matter up with the county public health committees later on. It is only necessary to add at this time, that without some such system of scoring dairies, it is impossible to develop sanitary dairies.

In conclusion we would present the following:

1. Dirty milk, and that is the kind the great majority of citizens of California are drinking to-day, owing to its bacterial contamination, is dangerous to the public health and is the cause of much sickness and death, particularly among infants.
2. The lay people of our state drink this milk which is a menace to their health and lives because the medical profession of California has not done its full duty in educating them concerning this danger.
3. When the laity are once educated concerning this menace to their health and lives, they will gladly co-operate in all intelligent and sane efforts for the production of a milk supply that is clean, pure and safe.
4. The logical persons to carry on this campaign of education are the members of the medical profession.
5. Through the Public Health Commission of this Society and the public health committees of the county units, we have the basic organization necessary to the inauguration and development of this work throughout the state.
6. The Public Health Commission serves notice on you at this time that it intends to push this particular work during the coming year, and that it counts on all members of the Society, individually and collectively, to co-operate.
7. Further, THE JOURNAL will contain notes of the work as it progresses. The Commission invites correspondence from those who are interested.

## SANITARY SUPERVISION OF BAKERIES AND RESTAURANTS.\*

By L. M. POWERS, M. D., Los Angeles.

The inspection of foodstuffs from the market to the table has not engaged the attention of the sanitarian or the public to the extent that it deserves. While much interest has recently been manifested in the inspection of foodstuffs for the market, little attention has been given to the manner of handling them after leaving the market and while undergoing preparation for the table, a period during which foodstuffs are subject to many manipulations, oftentimes by careless and unscrupulous persons who have only a shortsighted monetary interest to serve. The bakeries and public kitchens are the places where many of the tragedies of the digestive system are planned. All cases of ptomaine poisoning do not originate in the butcher's cold storage or market, but often in the poorly kept and over-worked icebox of the restaurant or eating house.

How often infectious diseases are contracted in these eating houses we do not know, but we do know that many times the exposures are very great. Where the napery and table ware are well boiled, and no food once served on the table is again returned for another consumer the danger is greatly minimized.

In bakeries conducted without proper regulation and supervision you would be surprised to find that there is a total disregard for sanitation. It may be that the bread and pie served on your table is baked in a place that the flies, dogs, cats, chickens and rats have free access to. I have seen a table on which pies were being made literally black with flies, a hen's nest in one corner of the room; and the excuse given for not having screens on the windows and doors was, that the cooking was done at night time when the flies were not active.

Breadstuffs are often hawked around town through the dust-laden streets and alleys uncovered, handled by dirty and, perhaps, diseased hands, and are left, unprotected from filth, on the back porch.

Should you go into the kitchens of some restaurants or eating houses, perhaps where you get your meals, you would be surprised to find the floor reeking with filth, odors arising therefrom not at all conducive to a good appetite; the icebox sour and containing strong evidence of incubative purposes; the water closet in very close proximity to the food, the toilet room being ventilated through the cook-room; and the cook and his helpers suffering from some form of infectious skin disease. Rats, flies and other insects playing and feeding on the food which is to be served; the dishes run through lukewarm water, and wiped, if at all, with a dirty cloth; the knife and fork retaining a visible portion of the egg some poor tubercular person ate at the meal before; the scraps from the table carefully sorted, and placed aside to be served at the next meal; the milk allowed to stay in the alley near the slop cans until received with dirty hands, then robbed of its cream and the cans set on the floor where the insects and

cats have free access to the contents. In these places also alterations and substitutions are carried on to a great extent. The patrons, it is needless to say, do not see these conditions, and do not realize the danger therefrom, therefore the careless and unscrupulous restaurateur or caterer does not feel called upon to make any changes so long as he is not losing trade.

The sanitary regulation of bakeries, "pie factories," restaurants and eating houses by good sanitary laws and a system of inspection will bring about such beneficial results as will be appreciated by the most skeptical. The chief points to be considered in these regulations and inspections may be summarized as follows: a sanitary building, by which we mean a building constructed of such material and in such a manner that it can be kept clean and well drained, mouse and fly, or, in fact, insect proof; provided with separate rooms for storage, cooking, dressing, and toilet purposes. The bread and pies handled by healthy, clean and careful persons. The distribution of breadstuff should be made in a manner to protect it from dust, flies, and uncleanly or diseased persons.

In public eating houses there are all kinds of food to be protected from insanitary handlings and surroundings. The store-rooms ought to be kept clean and free from insects and mice and rats; the ice chest should be clean and uninfected; the floors clean and well drained, and proper provision provided for scalding and cleaning all table ware; the workers should be free from infectious diseases and clean in person, and the food should be wholesome and uncontaminated by insects or filth of any kind.

## SYMPOSIUM ON PURE FOOD.

### Discussion.

Prof. Jaffa, Berkeley: It seems to me that these are very interesting and instructive papers and exhibit great progress in the pure food movement. Such efforts are a wonderful help and encouragement to those who are engaged in this movement. I think such efforts are along the right line,—that is, educating the public or layman. If the public is not educated then our work is not going to be of value. Who is better able to educate them, primarily, than the doctors, and secondarily, the Mothers' Clubs, because you will find that whenever a Mothers' Club takes hold of a proposition of this kind, that proposition is successful. If a Mothers' Club should boycott certain goods, the dealer of such goods would have very small chance of selling those goods. Illustrations for such cases are many. Take the case of the dried fruits, and at the present time that is an extremely important question on account of the agitation going on,—and if the public was educated to understand that these highly yellow colored fruits, no matter of what kind, are not so nutritious and do not possess as fine a flavor, there would not be the demand for yellow dried fruit. If they understood in the case, the large amount of sulphuric acid they contain, there would be no sale for them. But the layman does not understand and consequently these articles are the ones which are bought. It is the same way with the desiccated vegetables. Vegetables are a food the value of which is not thoroughly appreciated by many to-day, but the fact that they are nutritious has led to their being treated in such a way that they can be imported. In the preparation of some of these vegetables, bleaching

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is carried on to such an extent that the vegetables contain 1% of sulphuric acid. Are these nutritious or healthful? No. How many of us thoroughly understand the value of skim milk. Many think that the nutriment is gone and skim milk has little value. In a good many cities to-day the sale of skim milk has been prohibited. Such ideas are carried altogether too far. We all know of the sale of skim milk in Denmark where they have the different grades of milk and no man is afraid of it. So our line of improvement has a great deal to do with the matter of educating the public. If we look over the amount of adulteration which has been practiced, less than 15% is due to preservatives and the rest to the fruit. With reference to the meat question, the sophistication is decidedly less during the past two years than it was previously, owing to the United States meat law. That exercises supervision on products manufactured in one state and sold in another. The goods manufactured and sold in the same state, are not supervised. That is why it is such a necessity to have a good state law. The Federal laboratories cover only goods manufactured in one state and sold in another. With reference to the meat packing houses which manufacture any class of goods to be sold outside of California, they are subject to Federal inspection and that is extremely rigid and the law is enforced. The Federal law prohibits the use of all preservatives and only allows the common preservatives like smoke and vinegar. The results certainly show the benefit of such a law. In the case of the mixture of mustard oil for salad and cooking, it is just as good as olive oil, but the question that is raised is over the labeling, for that is misbranding. Another issue is taken over the weights. So many boxes are labeled 25 pounds, whereas they contain only 19 or 20. When this is detected the manufacturers claim that the other fellow is doing it and that there are a great many other cases of misbranding. The United States law, however, is enforcing proper labeling of these materials and taking away the privilege of putting on any kind of labels. Much is also being done with regard to coffee substitutes.

Dr. Ward, University of California: I have listened with a great deal of interest to the accounts of the progress that Los Angeles has made along the lines of clean milk. Pasadena is to be congratulated also upon having brought about the tuberculin test. I have participated in two failures of that kind and can appreciate the difficulties of this work. Palo Alto tried this scheme several years ago and failed. Berkeley has tried for three or four years to bring about these results and has practically failed. The matter is still hanging fire. The trouble is that we have neither the medical profession nor the laity with us. I want to emphasize the difficulties in bringing about that great change in dairy industry which the tuberculin test means. In Berkeley to-day 18% of our cows are tubercular. Dairies with 100 or 200 cows supplying San Francisco with milk have 20% or 25% tubercular cows. If this fact can be hammered home to you,—the medical man,—and its significance, you will realize the necessity for the crusaders to have your support. We can have more ordinances passed in that way and we can stop the evil by state appropriation. The state will not appropriate the money. It has been tried in a dozen states and has failed. We can only get at this by education of the consumer and that must come through the family physician. When the consumer demands it he will get it. Another phase of progress here in the south is the certified milk movement. Oakland made a little start in this line several years ago, in the absence of action by the local medical society, through the Oakland Home Club, which took up the matter and assumed the responsibility. We have had a dairy there for three or four years which has been distinctly in the process of evolution.

I think no one realizes, outside of those working on the subject, as we do, the improvement that that dairy has shown. It is getting to a stage where it is very satisfactory. It has been a case of evolution of the dairy in the hands of the poor man. He had not the capital to put in it and so he made his progress in proportion to the demands of the people. He has 93 cows now supplying Berkeley. San Francisco has just now established a certified dairy which is only a week or so old. I recommend that the San Francisco physicians urge the support of that dairy by notifying the public of it.

Dr. F. M. Pottenger, Monrovia: Clean milk is a very costly proposition. We have voted for a good dairy (in my town), we have a tuberculin tested herd and have a clean dairy, but we have great trouble to get the dairymen to understand what we want. They are dirty and cannot understand our principles. I can easily see what trouble the uneducated man would have in getting these men to do what we ask. Our milk is now produced at the cost of 25 cents or 27 cents a gallon. Milk cannot be produced at only the one price. We must educate the people that they must pay for this cleanliness. But it is the same in other matters, we have had difficulty in this country in getting things produced clean. Dr. Powers has detailed to you the conditions of kitchens. It is all so, only we do not see these things as they are. I have had great difficulty in getting a clean cook, and now that I have a man who understands what I mean by cleanliness and is willing to do what I want, he has to discharge his under help four or five times a week in his endeavor to find the right man. I have, however, a kitchen I am proud of. But my cook has to discharge his men for dirtiness and because they will not obey rules, and he has great difficulty in finding men who can understand what cleanliness really is. The class of men doing kitchen work in this country to-day are a lot of hoboes and one simply has to stand over them with a club. You will find that it is a mighty hard thing to get things produced as they should be produced. I have been giving talks to our help at home in an endeavor to have them co-operate with us, but the average man does not care. These are the men who cook our food and handle our food throughout the country.

Dr. Geo. A. Hare, Fresno: I would like to emphasize the necessity for the medical profession to back up this movement for pure milk. Some years ago some member of the Board of Health in Fresno inaugurated the pure milk movement. Every cow in the county was certified and tagged and registered and had the tuberculin test. We maintained this for a number of years and had good milk. It closed up about one-third of the dairies which supplied Fresno, while two or three organized and milk went up two and three cents a quart. The Board of Health had the responsibility and they did not lose any prestige and the dairymen flourished, while the public was satisfied. The point is this, that so long as the Boards of Health of our cities are dominated by politicians, so long will this movement be a failure. The moment we have a Board of Health manipulated by political interests, just then will it fail. There is constant failure before us because every election we have these places in the Board of Health filled up by political pull. It keeps the Board of Health crippled and is demoralizing to the best of work. Let the medical profession exert an interest that will manage and control every Board of Health; that is a logical part of the duties of the profession, it seems to me. If we insist upon the Board of Health being under the medical profession, we lay the first foundation. Without this I believe our work will prove a failure. This work is work of reform and it is to get the foundation so that we can get control of the Board of Health, for which we must strive.



Dr. Chas. G. Levison, San Francisco: I would also like to say a few words with regard to the milk supply being controlled by these municipal Boards of Health. I do not think that that is the way it should be. The milk supply must come as a matter of state legislation. In the City of San Francisco the milk comes from herds of cows that are tuberculous, and the milk comes into the city from surrounding counties, so that the Board of Health cannot control the care of the cows. The Board of Health has power to control the milk situation only up to a certain point, but not to determine the source of the milk. When it was called to my attention that the milk which we receive in San Francisco was the milk from tuberculous cows, it was a matter of great astonishment to me. The people are not familiar with that fact. This problem is one of the greatest magnitude and attempts have been made in a number of cities to rectify milk conditions, and these attempts have been failures. If we attempted to destroy the cows that are tuberculous, it would be a tremendous thing. The subject must be approached in a very slow manner. Ward, of the University, has said that tuberculosis among the cows has been eliminated by isolation of cows after the cows have calved and the calves have been raised on sterilized milk. Eventually this would eliminate the tuberculous cow and it seems to me that this method would be a correct one.

Dr. T. C. McCleave, Berkeley: I cannot agree with the speakers who have brought up the question of politics. I think the introduction of pure milk depends upon the attitude of the family physician among his patients. In my own practice, for instance, I have had to do with a great many families having small children. Not one family is supplied with any other milk than that from the certified dairy. This is the whole proposition. Probably when we tell these mothers that they must get their milk from the certified dairy, they will reply that they cannot afford 12½ cents and 15 cents per quart; that she is only paying 10 cents at the present time. I then explain to her the value of the other milk, that the baby must have it, and that the extra cost per month for the certified milk would only amount to \$1.25, and I tell her that if she says she cannot afford to pay \$1.25 per month more for the care of her child, then I do not want anything more to do with her family. I have never had a mother tell me yet that she would not afford this extra amount per month. If every physician having to do with children would put the matter up to the mothers, it would not be long before the mother would be taking the pure milk for her children. I watch the milk myself. We have been handicapped by only one dairy. When the mothers complain that the milk does not look good, I order that they bring the milk to me at my office and I have it examined and so keep track of its condition. Some of this milk looks quite pink and we find out that the cows have been milked too soon after calving and we have such things stopped. Show the people that you are interested, and as I say, if you family physicians will do this, it does not make a particle of difference what the politicians do or whether the tuberculin test is enforced or not. When pure milk is demanded by the people, pure milk will be supplied, and not before.

Dr. J. C. Spencer, San Francisco: It has impressed me that this whole matter is a proposition of educating the public. Of course the matter of the price of pure milk is a very serious factor. As I understand from the dairy authorities, they cannot produce certified milk as long as it is sold at 15 cents a quart. By way of suggestion, if the lay-public is to be educated we must extend the first process of education. If any given community has a dairy where certified milk is produced, a simple means would be to take the owners of the other dairies and force

them to come to the dairy where certified milk is produced and let the certified dairy stand as an object lesson.

Dr. Martin Regensburger, San Francisco: This is clearly a case of education. The public must become interested and the school children and the women must be educated. If the doctors were to go before the teachers' institute and talk to them, and educate the children, a great deal of advance could be made. It is a matter of the most importance.

Dr. W. S. Fowler, Bakersfield: One of the best means for educating the public has been neglected. The greatest means for improvement is that of public information through the press. Dr. Aiken of Fresno says that he has no doubt but that the milk would have been improved materially if the newspapers published data comparing the different areas and their progress. If competition can be brought about an immense amount of labor can be saved.

Dr. W. C. Rucker, U. S. P. H. and M. H. S., San Francisco: For the information of the members I will say that there has been issued quite recently a volume of important studies on this milk question. It is a study of the milk in the District of Columbia. Those of you who are interested will find this book worth while. It is the most exhaustive thing I have seen, and was recently published by the Public Health and Marine Hospital Service.

Dr. Jas. H. Parkinson, Sacramento: This whole question consists of the education of the public. If the public is properly taught there is no question but that we can accomplish all we signify is to be done. In this connection we cannot but wonder at the situation in San Francisco at the present time. The Mayor of 1908 has thought best to put up a Board of Health consisting of five laymen and two physicians. Whether this was done from the sanitary or the political standpoint I do not know. I think that such a step should be considered. I think we have several new problems before us to-day. As it has been pointed out in Los Angeles, we have the question of housing. Our cities are becoming larger and we are growing up in the air as well as along the ground. In addition to the Japanese and Chinese we have the European population, and these all present some problems and difficulties. With regard to the milk supply and the milk control, it has been questioned whether the Board of Health can control the milk problem from outside. It can be done, I think, by the public being informed. In Sacramento our milk is coming from out of town. We have compelled the milk men to get numbers and be registered. The pure milk and the certified milk is going to be a difficult thing to bring about in our country. When you consider the neighborhood of the dairy yard and remember our rainfall, and that the dairies are along the bottoms of very large rivers, it is going to be impossible to keep decent dairy yards. We can build them on mounds and they will be in mud. It is impossible to keep things clean. I do not know what is the best thing to do there. With regard to the care of the milk in transit a great deal has been accomplished. You know what it generally means to take the milk to town and bring back garbage in the empty cans. Much has been done toward rectifying this condition. Another problem against which we contend is the use of the milk cans for making coffee in restaurants. The milk comes in, the coffee is added and the cans are put right on the range. The public must be taught the importance of these questions. Another point is the question of contamination with flies. Enormous stress should be laid upon that point. Flies are our arch enemies. We also have to deal with the question of dust and exposure of vegetables. The vegetable man complains that he cannot sell fruits and vegetables unless they are exposed to the view of the public and are where they can be handled. We are going to try to stop this. If we can only show

the public that it is for their benefit that we want these things and that it is not going to cost them a cent, we will be able to get their co-operation.

Dr. Edward Gray Eldridge: This question has come to my attention in a somewhat different light than to the rest of the profession. I am serving the State of California at the California Home for Feeble-minded. We have a herd there of about fifty-four or fifty-eight cows. The state sends annually and sometimes semi-annually a veterinary to inspect this herd. Two years ago the result was that we lost twenty-three of our herd on account of the reaction to the tuberculin test. You would be surprised to know that often it is not the lean and thin cows, but the very finest and choicest animals which will react to the tuberculin test. We have had post-mortems on every cow which has been condemned and every time the results show the advantages of the tuberculin test. We have found the abscesses, with the cheesy degenerations, in no matter how healthy the animal which reacted. Since this inspection two years ago we have not lost so large a number, because the herd was so thoroughly weeded out. At Eldridge we have under our care epileptics, feeble-minded, imbeciles, idiots, etc. They are not the cream of the land, but we undertake to care for the health of the children committed to us. If the state can take care of its least desired population, certainly the medical profession should join together in taking care of the great body of children and adults under its care.

Dr. Wm. Simpson, San Jose: We tried years ago to force every dairy to the tuberculin test in Santa Clara County. We passed ordinances to that effect and put two-thirds of the dairies in Santa Clara out of business because of the cows that were killed. We taught the people of the county that it was necessary to have this law and that the dairymen could not sell a cow in Santa Clara County unless that cow had been tested. For a few years we have had no regular inspection, but in the last year this has been taken up again and no dairyman can sell a quart or pint unless he has a license which carries with it the necessity of certified milk and a clean dairy. These rules are not only from the tuberculosis standpoint, but they average up what the milk inspector thinks is the proper standpoint. At first we prosecuted every milkman who sold impure milk and revoked the license when the milk was reported below the standard. Our milk comes from quite a distance outside of the county, from Gilroy and Watsonville. A few years ago the Boards of Health wanted a satisfactory Dairy Bureau, but the milkmen assessed every milk dairy in every city \$2 a cow and they went to Sacramento; the Dairy Bureau is now composed of milkmen.

Dr. F. L. Rogers, Long Beach: I feel that the matter of pure foods is not to be passed by without a little more being said along the line of some of the practical results of work of this kind among the little folks in our public schools. There has been started in different parts of this state a movement, the result of which shows perhaps as well as any other movement which we have had, the need for work of this kind in the interest of the growing children. In Los Angeles there has been in connection with the public schools a movement for the inspection of the children. The Board of Health and the Board of Education have taken this work up in an active way and they now have examinations for the public schools. The results of that examination are such that it seems to me that they cannot but see the great importance of the inspection along the line of pure foods, pure milk, and also the benefit from pure air and sanitation and other matters in general. In our little town of Long Beach the work was undertaken in 1906, and while it was a preliminary work there, the board took the matter up with the idea of first determining how many of the children were defective in sight, hearing, throat and

nose. The work was placed in my hands and I have just completed the work of examining 3,480 children in the public schools. Incidentally I have examined the children's mouths and teeth, and you would be surprised to know how extremely few children have good teeth. There are less than twenty per cent with sound teeth, and I believe carelessness and adulterated foods are responsible for it. Sixty-one per cent are deficient in one of the four special senses. The greatest deficiency is the sight in one or both eyes, and there is also deafness and adenoids. These are just a few of the statistics that I remember, but the figures are to be had and also those of Los Angeles. The work has been carried on in a much more extended way, making the examinations of the whole body.

Dr. F. C. E. Mattison, Pasadena (closing discussion): One word with reference to the term certified milk. Certified milk means milk certified to for cleanliness. I am very glad to know of the work being done in Alameda County and that the owners have to sign agreements, and that a violation of the agreement means a fine of not less than \$500. The dairyman has to come up to certain requirements and has to agree to furnish the dairy in certain ways and to do the milking in certain ways, and a violation of this should mean a fine. In Pasadena we allow the certified milk a maximum of 20,000 bacilli to the cc. This has been coming down and we hope it will come down to the limit. When this dairy is in the perfect working order that we expect it to be, we will keep well below this amount. With regard to the organization of this work, the plan pursued by the Pure Food Commission has been to interest the ladies. You will find that if you get the women's clubs interested you can organize this work. Get the women of the clubs together and tell them the plans and the reasons and you will find that you have a force at work greater than any medical societies. In no other way could we have carried on this work if we had not interested the women's clubs. They have more wit than we have in getting the things that they want. The great thing to overcome is the ignorance of the laity. In our work we had our inspectors and we had meetings of the various bakeries; we had the representatives from the clubs and we laid the matter before them. I had in my possession bills from the vegetable houses and dealers in supplies who had been supplying these bakeries. I had bills for cases of rotten eggs which they use in these bakeries, adding a preservative. And when the representatives of the clubs and the laity understood the condition, with their help and that of the good bakeries, we carried our ordinance. The Medical Society of California is a power in itself if we use it properly. What we lack is organization. We must make each man feel that it is in his power to get the pure foods that we want.

Dr. G. H. Kress, Los Angeles: If the county of Los Angeles can get pure milk in five years, the State of California can certainly get it in five years. There is another point in which we need help. The County of Los Angeles, in order to get a grip on the dairies, asked that one of the city inspectors be deputized as a state inspector. In that way the interest of the state would be a safeguard. I believe that we will get clean milk in California in five years.

Dr. Stanley Black, Pasadena: With regard to the meat question, unfortunately all the meat which cannot pass the U. S. inspection is turned into the State of California. This should be stopped by the Boards of Health. We should combine with the United States in that regard. We have in Los Angeles an ordinance to inspect all slaughtered animals and it is working out well. In regard to the tuberculin testing of cattle, we should have statements with regard to what some of us are working for. We began the tuberculin testing of cattle in

Pasadena eight years ago. The public was not then interested and did not understand. But every cow there must be tested and we are now using the Government tuberculin, which is the best. With this we are working in conjunction with the Marine Hospital and the meat inspectors of Los Angeles. In testing the cattle we have a great deal of trouble with the veterinary and we are giving him pointers. There were hundreds of cows that were sacrificed that were never tested at all. Now we require a report from every cow tested, and all of the cows must be branded. If we can only spread this work throughout the state it will insure a state law.

### LUETIC STIGMATA OF IMPORTANCE TO THE GENERAL PRACTITIONER. \*

By HERBERT C. MOFFITT, M. D., San Francisco.

In consultation, as in ward work, the question of an old syphilitic infection must frequently be raised. Wise skepticism is nowhere more in place than in dealing with a negative history in face of a suspicious clinical picture. Crocker got no history in 20% of his cases of tertiary syphilides. The dictum of Gowers is to be remembered,—“If there has been any possibility of exposure to infection, the disease cannot be considered to be out of the question.” Of the greatest importance at times is the suggestion given by this or that earmark that indefinite and obscure symptoms may be due to syphilis; a tibial periostitis may give another direction to the treatment of an ill-defined “neurasthenia”; an Argyll-Robertson pupil may explain the true nature of obstinate intercostal pain; a palmar syphilide may change the prognosis of an irregular liver tumor. It is the aim of this paper to emphasize anew the importance of certain stigmata in diagnosis.

1. The *facies* may be suggestive. The small, wizened, puckered face of congenital lues needs no description. There is a puffy, stupid, greasy face rather peculiar to cerebral lues. Scars at the hair border or over the forehead, a sunken nose, ptosis or strabismus excite suspicion at first glance.

2. The *skin* shows many signs. This is not the place to describe the varied dry or ulcerative late syphilides. They rather characteristically lack polymorphism and are apt to be regional. A woman seen some years ago with cerebral lues had a tubercular syphilide of the nose and adjacent cheek. A man with gummata of the liver had rupia of the trunk. A man with great pain and stiffness of the back wandered to several springs for relief of rheumatism; he had a beautiful bilateral palmar eruption, and got perfectly well under mixed treatment. It should be remembered that this palmar psoriasis may occur many years—Fournier cites 15 and 31 years—after infection. Sharply cut, round, crescentic or serpiginous ulcers, especially if indurated and grouped regionally, are most suspicious. Frontal ulcers or scars are not common. A woman seen 9 years ago in the clinic had vomiting and headache with optic neuritis and circular pigmented frontal scars. A young woman for years treated for lupus had serpiginous pigmented scars over the trunk and

both things, and massive thickening of both tibiae. An old physician had for two years a large and tender liver referred to malaria and peculiar nocturnal suffocative attacks labeled asthma. He had extensive oval ulceration over the front of both tibiae about the middle of the leg that had been treated for three years as varicose ulcers. Under iodide and mercury he made a rapid and complete recovery. Varicose ulcers are usually below the mid-leg and on the inner side; ulcers near the knee are apt to be luetic. Ulcer of the penis may recur at the site of the original chancre, and be mistaken, if indurated, for a recent infection; a young man seen during the last three years has had three recurrences of an indurated ulcer in the sulcus at the seat of the original sore.

Linear scars about the lips may mark congenital victims. A young woman seen lately with syphilitic joints had these puckered scars as the only stigma. Depressed, circular, brown pigmented scars grouped over the trunk or about the knees or over the shins are frequently of syphilitic origin; the scars of trauma or varicella most often lead to confusion. Recurrent herpes of the penis should be given some weight in diagnosis. A young man with indefinite night terrors and headache was long labeled “neurasthenic” until a history of recurrent herpes gave hint of a specific origin of the symptoms. He got well under specific treatment, and his two children, seen later, were typical congenital syphilitics. A man with peculiar cerebral symptoms gave history of several infections with gonorrhea, but knew of no lues. He had recurrent herpes genitalis, and was cured by a course of mercury and iodide. A man with tabes had recurrent attacks of herpes for years.

The notched and peg-shaped teeth of congenital cases need but to be mentioned. In a boy of eight, broken, thickened and rudimentary finger nails gave a hint of the cause of long standing enlargement of liver and spleen.

3. *Glands*. Enlarged posterior cervical and epitrochlear glands mark a recent rather than old infection. They are frequently found large without any evidence of syphilis, and their importance in diagnosis of old cases has been much overrated.

4. *Bones*. Exostoses are frequently syphilitic. A man seen in 1899 had a painful tumor over the right parietal bone and Jacksonian epilepsy; both were cured by specific treatment. A man seen in 1902 had cerebral lues, a biceps contracture, a painful node on the right humerus and ulcers of the leg. A woman with scars on the tongue had a thickened right tibia. An old man seen this year with cerebral lues recovering under specific treatment had a thickened right tibia that at first suggested Paget's disease. Painful nodes on ribs or sternum are not rare. A man seen last week has had during 8 years painful nodes recur on parietal and frontal bones, both ulnar and radii, both humeri, scapulae and femur.

5. *The nose* is frequently attacked from without and within by late syphilis. The deformities from external and internal destruction have already been mentioned. Rapidly obstructing gummata may

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be mistaken for sarcomata. A young man, who denied infection, was seen six years ago with a tumor blocking the right nostril. A fragment removed was reported as sarcoma, and operation was contemplated until iodide led to rapid disappearance of the mass and to a confession on the part of the patient. In a woman seen lately an exactly similar condition maintained. Ulcerative gummata are most frequent on the bony septum, and frequently lead to perforation. Not all perforations of the septum are syphilitic, but they should at least suggest the possibility of such origin. Last year a man was seen in a peculiar mental state that had been referred to overwork and worry. The possibility of syphilis had not been suggested, as the man was regarded as "above reproach." There were no signs but an optic neuritis and a perforated nasal septum, but recovery was rapid under mercury and iodide. A woman seen seven years ago had cerebrospinal lues and extensive destruction of the nasal bones—her son aged 12 had a perforated nasal septum and Hutchinson teeth. Ozena is, in my experience, more frequently a sequela of syphilis than the writings of specialists would have us believe. (See article of *Sendziak* "Atrophic Rhinitis" *Annals of Otology, Rhinology and Laryngology*, Dec., 1907, page 819). The pleasing verse of *Ambroise Pare* may be cited:

"S'il tombe quelques os du palais  
Danger y a d'estre punais."

A young man developing epilepsy in the last years had ozena of about the same duration; he has been free from attacks under specific treatment. In a mother and son, both syphilitic, ozena was a most distressing symptom. In a man seen lately the syphilitic origin of obscure symptoms was first suggested by the odor from his nose.

6. Examination of the *mouth* should never be neglected. It is a fact not generally recognized that mucous patches may appear years, many years, after infection. *Scars* may be seen upon hard or soft palate, the pharynx or the tongue. Extensive destruction of the soft or hard palate may take place rapidly, or slowly and insidiously, and perforations result. A woman with tabes had ulceration involving almost all of the soft palate. The tongue is very frequently the seat of gummata as of mucous patches. There may be superficial plaques or deeper tumors, or cracks, fissures and lobulations. Gummata are most often lateral and dorsal, and commonly lead to ulceration. A man seen recently with hemiplegia, nasal bone destruction and a clear history of other syphilitic manifestations was about to have the tongue removed for carcinoma until iodide was suggested. An old man seen four years since had both gumma and carcinoma, the latter developing on the site of the neglected gumma. Smooth atrophy of the tongue, first described by Virchow, was seen last year in an old woman with tabes; its significance was reviewed in 1905 by N. B. Potter of New York.

Keratosis or leukoplakia of tongue or cheeks is frequently but not necessarily or directly of specific

origin. Patches on the cheeks were recently observed in a man, not a smoker, whose infection dated back 30 years. A woman seen two years ago complained of obstinate pain in the right hypochondrium, which was associated at times with a girdle sensation. There was a history of transient diplopia, of lightning pains, and her husband, seen lately, has leukoplakia and advanced tabes. A woman examined last year had a marked secondary anemia unexplained until her husband was found to have very marked lingual keratosis and an aortic aneurism.

Hemiatrophy of the tongue, when not due to peripheral hypoglossal nerve injury, should suggest syringomyelia or tabes.

7. *The eye.* Interstitial keratitis is not rarely seen in congenital cases. A girl of three was brought to me five years ago on account of malnutrition. Liver and spleen were enlarged, and her father had been seen for a peculiar nervous state with no definite symptoms other than transient aphasia. He denied lues, but had of late years recurrent herpes of the penis. The child was given mercury and chalk, but treatment was neglected, and she came back three years afterward with blepharospasm and nearly blind from keratitis. Recovery was perfect under specific treatment. Two sons of a father who had rather unaccountably developed acute neurasthenia and who also had many recurrences of herpes of the penis without history of chancre presented interstitial keratitis, lip scars and other signs of congenital lues.

Syphilitic iritis may be a late lesion; a man seen this year in hospital had signs of cerebrospinal lues, lymphocyte increase in the spinal fluid and an acute iritis. It is well known how frequently extrinsic eye muscle palsies owe their origin to syphilis, directly or indirectly. Nothing is more common than to hear a tabetic tell of several periods of transient diplopia. Slight degrees of ptosis should not go unnoticed. The first glance at an old woman who came to hospital this year on account of an indefinite stomach disorder suggested a syphilitic cause of the gastric symptoms as well as of a slight ptosis, and the results of treatment confirmed the suspicion. In a young woman seen last year a gastroenterostomy could have been left undone had the surgeon followed the hint of a well marked ptosis that the pain was that of a gastric crisis and not of ulcer. A man examined last year had been treated for months as a case of trichinosis (despite absence of eosinophilia) because of intense muscular and nerve pains. In addition to signs of dorsal nerve root trouble there was an optic neuritis and unilateral ptosis, and he has greatly improved under treatment. A man entered hospital this year on account of a recent diplopia. He had pupils almost inactive to light, no knee jerks and many lymphocytes in the spinal fluid.

Much more important than the paralysis of extrinsic ocular muscles, (because this is most often a transient phenomenon), is the confirmation of pupillary changes. Babinski says that an Argyll-Robertson pupil always means syphilis. Moebius' sentence may be recalled "Die reflektorische Pupil-

lenstarre ist bereits beginnende Tabes." In some cases the loss of light reflex is unilateral. A slow reflex is of import; and at times (it has seemed to me more often in the pseudo-tabes of cerebrospinal lues) reaction to accommodation is lost as well as to light. Small irregular pupils in a young adult are suspicious, especially if there be a sudden irregular cleft in an otherwise unchanged outline. A man seen two years ago had been operated upon for gastric ulcer, although inactive pupils should have suggested the possibility of gastric crises. A man seen two years ago had a hard tumor of the right testicle, marked arteriosclerosis and Argyll-Robertson pupils. A man examined last year had nephrorrhaphy done for relief of pain due, in light of inactive pupils and absent Achilles jerks, to disease of the dorsal nerves. It is so easy to examine pupils as a matter of routine, and so much may be learned, that it is a matter of constant surprise that so little attention is paid to them. An Argyll-Robertson pupil may shed new light upon an indefinite neurasthenia, an obstinate trigeminal or intercostal neuralgia, an aortic insufficiency of dubious etiology, a mysterious stomach affection, or a persistent paroxysmal cough.

It is impossible to lay too much stress upon the importance of the ophthalmoscope in diagnosis. A specific choroiditis, an optic neuritis or a primary or secondary optic atrophy may give valuable hints of specific disease. A man seen three years ago had been treated for several months as a stomach case by reason of frequent vomiting and indefinite abdominal pain. An optic neuritis was the first suggestion that the underlying cause was cerebrospinal syphilis. Mention has been made above of a case regarded as one of nervous breakdown, in which the peculiar mental hebetude, an optic neuritis and a perforation of the nasal septum led to the recognition of the syphilitic origin.

8. *Vascular Changes.* Early arteriosclerosis, if not due to kidney or adrenal disease, lead or diabetes, is most suspicious of syphilis. A persistent high blood pressure without marked arterial change has in several instances suggested the possibility of a luetic cause. Aneurism is nearly always a syphilitic product or by-product; out of fifteen cases seen in private work all but two gave positive history or signs of a previous syphilitic infection. It is frequent in patients with old syphilis to find evidence of an aortitis—pain under the sternum, angina attacks, a dilated arch, an accentuated aortic second, a systolic aortic murmur, insufficiency of the aortic valves. Conversely the determination of such signs without satisfactory explanation should suggest the possibility that the patient has had syphilis. A young woman observed last year in hospital had syphilis of the nervous system, a large liver and a dilated aortic arch with a systolic aortic murmur and accentuated second. In a case cited above of diplopia with pleocytosis, there was an aortic insufficiency without history of usual infectious causes. The frequency of aortic insufficiency in tabes is well known. Myocardial insufficiency in young or middle-aged men rests not uncommonly on a syphilitic basis, and will be benefited far more by mercury

than by digitalis. Mueller and Rogge from Struempell's clinic have lately emphasized the frequency of diseases of the circulatory system as a result of syphilis. (Tabes dorsalis, Erkrankungen der Zirkulationsorgane und Syphilis. Deutsch. Archiv fuer klinische Medizin. Bd. 89, S. 514.)

9. *Nervous System.* It requires but a few words to elicit the important suggestive history of lancinating pains, diplopia or sphincter disturbance. A few minutes suffice to examine pupils, to test the knee and Achilles jerks, to determine ulnar hypalgnesia or hypalgnesia over the trunk, to glance at the eye grounds, and yet the facts so determined may be of far reaching importance in diagnosis and treatment. Erb has recently contributed a valuable paper, "Ueber die Diagnose und Fruehdiagnose der Syphilogenen Erkrankungen des zentralen Nervensystems." (Deutsche Zeit f. Nervenheilkunde. Bd. 33, S. 425.) He recalls particularly the diagnostic help of lumbar puncture in determining a lymphocytosis of the cerebrospinal fluid, "in zweifelhaften Faellen, wo der klinische und anamnestische Nachweis der Syphilis nicht gelingt, der Nachweis der spinalen Pleocytose das Vorhandensein der syphilitischen Durchseuchung in hohem Grade wahrscheinlich macht, ja fast sicherstellt, wenn alle klinischen Momente genau erwogen werden." In several syphilitic cases in hospital recently lymphocytosis of the spinal fluid has been determined, both in presence and absence of nervous symptoms, but it would seem a sign to use only in correlation with other findings.

10. *Unclassified Signs.* Justus hemoglobin test has wisely been abandoned. The curious intolerance of old syphilitics toward minute doses of copper reported by Brice (*Med. Rec.*, Nov. 10, 1903) has not been tested.

Certain trophic disorders may suggest syphilis—the painless loss of teeth, perforating ulcers, Charcot joints. During the last year two methods of diagnosis by serum reactions have been elaborated and extensively published. These are the precipitin reaction and the method by fixation of the complement. Review of literature may be had in the article of Erb quoted above.

Syphilis is a common disease amongst us. We meet it under many masks and in many unsuspected places. Its symptoms are legion, its signs protean. It strikes often at long range, and may attack almost any organ, and may injure in varied ways. A review of the signs that may be read as we run has seemed not unnecessary in light of my own and others' shortsightedness.

#### SYPHILIS AS SEEN BY THE EYE, EAR, NOSE, AND THROAT SPECIALIST.\*

By HAYWARD G. THOMAS, M. D., Oakland.

In considering this subject, my conclusion is that we specialists see a great deal more of syphilis than we should, for the reason that it is the least recognized and the poorest treated disease in general.

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*Sometimes* we see a case that comes with a diagnosis of syphilis from a general practitioner. The majority, however, we discover for ourselves, and where no previous diagnosis has ever been made. Some of these are the innocent wives or children of syphilitic men; others who know they have the disease and give a history of some months' treatment for it anywhere from five to twenty-five years before; others who have had all sorts of symptoms and signs, and have been treated for all sorts of things—"catarrh," "sore throat," "malaria,"—and we find old scars in evidence in the soft palate and pharynx or a pronounced retino-choroiditis—the first sign of cerebral syphilis—and so on, through a long list.

Whose fault is this? The patient's mostly, for the average patient quits after the to-him-visible lesion is cured. The profession at large is at fault for the rest, for so many intelligent men tell us that they were treated for several months and discharged as cured, and I find that it is, or was, the view of not an inconsiderable number of the profession that many cases needed little treatment and will get well of themselves. The laymen know or learn just what we teach them so the onus is on us. Hence my statement that it is the least recognized and poorest treated disease.

We specialists see but rarely the primary lesions, and not much oftener the ordinary secondary lesions. Therefore, it will be mainly the tertiary lesions that I will bring before you, and instead of citing a lot of cases, I will deal with them principally in view of their diagnostic value.

Syphilis is the one disease that comes most largely into the etiology of eye diseases. Let us take a list of the principal ones:

- Iritis, acute and chronic.
- Irido cyclitis, irido choroiditis.
- Phlyctenular keratitis.
- Interstitial keratitis.
- Paralyses of ocular muscles.
- Periostitis of the orbit.
- Tumors of the orbit.
- Ptosis, especially bilateral.
- Many lacrimal strictures.
- Deep scleritis.
- Retino choroiditis.
- Many juvenile cataracts.
- Optic neuritis or papillitis, with hemorrhages into retina.

Optic atrophy.

Ocular symptoms preceding the others, of Tabes.

Notice that it attacks every tissue of the eye from the cornea to the optic nerve. Of iritis, sixty per cent are credited to syphilis, usually in the secondary stage, and about thirty per cent to rheumatism, but what I can learn and have been shown of old rheumatic cases, the pains and tenderness have very frequently been found in the middle of the long bones, and the pain mostly at night, too, so I have my doubts of the thirty per cent due to rheumatism.

Consider the large number of cases of interstitial keratitis we meet; always hereditary syphilis, and from patients of whom we can elicit no knowledge

of causes. We get syphilitic history plainly when we question the parents, but no history of treatment. One recognizes at a glance the dish-faced creatures with their aged look, the rhagades around the mouth, the notched and pegged teeth, and generally dull appearance which accompanies these cases.

Irido choroiditis is not so uncommon, and I remember Bergmeister of Vienna saying that if the Pope himself came with this eye disease he would say syphilis.

Many cases come that have such slight signs that we can only suspect, but it is the suspicion that often puts us on the right scent; the presence or absence of other confirmatory signs besides the therapeutic test telling the tale.

Not infrequently we are tripped up by the, apparently, refraction case that comes in to be cured of her chronic headaches, supraorbital usually. There is also often a little middle ear trouble, just a suggestion of hardness of hearing, may be a little tinnitus. All these symptoms are common enough not to excite suspicion at first of syphilis. We find in the beginning that the visual acuity is not of the very best, though not sufficiently below the normal to excite comment. Neither do the glasses increase the vision, and the patient soon comes back with her headaches. Inflation of the ear does not help her as it should in such a recent case. We examine the fundus again; there is a faint suggestion in the vessels and color of the retina and nerve that they are a little off-color, which did not impress us before. We have, simply, tripped up. Taking or sending the patient to a general practitioner, the body is gone over thoroughly, the suspicion of syphilis is confirmed, and the "off-color" of the nerve and retina was the first stage of retino choroiditis.

On the other hand, while we are smarting under this slip, comes a fairly young person with all these symptoms well marked—distinct loss of visual acuity with a slight refractive error, marked dullness of hearing, growing lack of comprehension, vacancy of facial expression, slowness of walk,—all these combined with undoubted retino choroiditis, and there is no doubt of the diagnosis.

Take another type: an elderly man comes in, introduced by his parson. I notice that the man is cross-eyed, and that is what he came to see me about. As he took hold of my hand, I noticed there was no grip whatever. His eye trouble was of a couple of months' duration. He had been treated by two general practitioners of standing, for stomach complaint, that, of course, to them being the cause of his eye affection. Elixir Lactopeptin I. Q. and S. from one, and I know it was a popular iron nostrum from the other. Looking further, I saw he had a facial paralysis, very slight but plainly brought out; plenty of scars in his soft palate and pharynx for which he had been treated three months the year before, but with no suggestion of specific trouble or treatment indicating a suspicion of it. I took the man at once to a G. U. specialist who immediately stripped him. The patient was like a sandwich



man; with signs all over him. I really find no excuse for the failure to recognize this case as one of syphilis, except the great rush to prescribe for a symptom and "call the next case."

The nose and throat do not present such a variety of lesions as the eye, and the ear reveals but little of interest in a diagnostic way.

In the nose and throat we see usually only the tertiary lesions. We find severe and extensive lesions involving the mucous, cartilaginous and bony parts. There are gummatous nodules or diffuse inflammatory processes in the submucosa. Untreated, the gumma breaks down as it does elsewhere, and foul, deep erosions take place. The bones and cartilage, being attacked, become spongy, honeycombed, filled with granulations, the bone being finally cast off. If extensive, I have only to mention the saddle nose with which you are all familiar. These tertiary lesions are hard to mistake. In the first stage, there are swelling and redness of the membrane, septum doughy, and all parts looking like stuffed cushions. The membrane becomes soon markedly paler, peculiarly so, and this is preliminary to the breaking down stage. Untreated, we soon see this, and we usually find a conglomerate mass of granulations, all landmarks gone as to what is septum or turbinate, discharging profusely and stinking horribly.

I find not a few cases of nasal polypi combined with antral suppuration, due to syphilitic necrosis in the ethmoid cells. After having cleaned out several nasal cavities and finding antral suppuration that others had overlooked, and then suddenly finding some tertiary ulceration in the soft palate, I concluded I was not a miracle worker myself.

This is not the history always, and we find cases that have gone a milder course, leaving a perforation of the septum, and possibly necrosis in the ethmoid, which keeps up for years a chronic little discharge. In diagnosing a case, if you had one come to you with severe crisis headaches, perforation of septum and necrosis of the ethmoid, would you give syphilis a passing thought?

We cannot overlook the otitis media cases that have been lightly touched on before. These may come either from the secondary patches around the eustachian orifice or gummata or tertiary ulcerations in the same locality. This subject is alone worth a longer and entire paper.

As syphilis tends to glandular enlargement, I wonder if sufficient thought has been given to it as a factor in the etiology of adenoids and tonsils, especially when the infant is born with an enlarged adenoid and has the snuffles, for, unfortunately, I know adenoids are not recognized in infants even when the poor things cannot nurse on account of "the snuffles,"—the direct result of adenoids.

Now, when all the children of a family have enlarged tonsils and adenoids from their entrance into this world, a certain proportion of these cases, I am certain, is from syphilis; but the question of these glands is not discussed as it ought to be and that could well be considered at some other time.

The larynx comes next and cannot escape you for everybody knows when a man is hoarse, and you

cannot ignore syphilis when you are considering the larynx. You will consider tuberculosis, lupus, carcinoma, and syphilis. The majority come down to the great two, tuberculosis and syphilis. Sometimes you forget that you can have both these in the same box, and only treat the one. And do not forget that. I will not go into the differential diagnosis. I have only tried to tell you what the specialist sees in his regular work, and the things that make him constantly on the lookout for syphilis, and why. We specialists cannot forget it for a minute, for it crops up in so many forms that we have less excuse for overlooking it than the general practitioner.

### SYPHILIS OF BONES AND JOINTS.\*

By S. J. HUNKIN, M. D., San Francisco, and GEORGE A. HARKER, M. D., San Francisco.

In speaking of lues as it involves bones and joints it appears best to give the salient points of a few case histories, not as a report of cases, but rather to present ordinary types as they appear with their characteristic marks to the orthopedic specialist. We are not intending to consider in this connection the trophic joints, for they are not luetic in the sense of this paper. Also we shall not speak of the classical hyperostosis of the tibia for you are all familiar with it. We shall rather deal with pathological conditions, which although fairly certainly syphilitic, are not usually suspected, and which are much more often encountered than we were wont to believe. They come to us labeled "growing pains," "rheumatism," "traumatic conditions" and the severer types are usually considered tuberculous. The part played by traumatism in the history of so many of the cases is so definite that we are led to consider it a factor—a factor not in the dyscrasia of course, but in the development of the bone or joint manifestation. This record of injury is not the somewhat indefinite remembrance of a fall or a twist which is so often remembered after the development of a tubercular osteitis, but rather there is the story of the injury, the bruise, the swelling, the disease, all following so closely on one another that it cannot be disregarded. It is, however, true that a tuberculous osteitis may develop rapidly upon an injury, but generally there is a period of ordinary function intervening.

Case 1. Girl 12 years of age. Family history negative, excepting that the mother is in an insane asylum. Diagnosis. Right hip disease of 4 years' standing. Severe type with several discharging sinuses. There was not so much shortening as is usual with so extensive disease, after such a period, though the significance was not realized at this time. The child also had spina ventosa of the 1st metacarpal bone in one hand, and of the 3rd metacarpal in the other. She did badly while under observation for several months, then the hip was resected, but she still did badly both locally and generally.

A sister was then noticed to have keratitis and Hutchinson teeth, and stigmata of syphilis were demonstrable in other members of a large family. The patient also, on further examination, was found to be developing fairly typical teeth which had before passed without comment. Under specific treat-

\* Read at the Thirty-Eighth Annual Meeting of the State Society, Coronado, April, 1908.

ment the girl was healed, both hip and hands in a few weeks, was fat and ruddy, and has remained well. The father died during the past year with aortic aneurism. Beyond doubt this hip was sacrificed, at a time when the stigmata were present, the multiple bone lesions were characteristic, and lues should have been suggested months before the operation.

Case 2. Girl of 6 years. Synovitis of the right knee, followed in a few weeks with a similar condition in the left knee. Family history negative. The swelling and effusion was accompanied with little or no pain, but with tenderness on pressure. On moderate doses of KI, the child soon recovered. Hutchinson has with truth said, that double knee joint synovitis of children, developing synchronously, or in close sequence, without any definite reason, can be considered luetic. These cases are not rare, and are usually mistaken for rheumatism. The children often have repeated attacks, which may occur earlier than the specific keratitis, or the specific teeth, and the diagnosis is rather important.

Case 3. Boy 6 months old. Italian. No history of lues obtainable. The child had not been nursed, and the feeding was execrable. During the last two months the joints of the extremities have thickened and ulcerated. The disease involved the shoulders, elbows, wrists and ankles. In all 14 lesions were evident. There was no skull involvement. Several points had perforated and presented small pin-hole openings. Bare bone was found in every place sought. The child continually fretted, though the passing of a probe to the bone caused no particular flinching. Mercurial inunctions with improved feeding over 4 weeks produced the healing of all wounds, and movable joints without apparent pain. A moderate thickening of the ends of the bones alone remained. The diagnosis of scurvy had been made, but the age, the absence of hemorrhage, the joint mobility, the comparative freedom from pain were against this. This type is fairly common. The multiplicity of lesions, with their chronic character and open sinuses point conclusively to lues. This particular child did better than usual. They generally die after a few months, and when they survive a few years they are miserable, stunted, hairless, deformed creatures. They are also prone to a secondary tuberculosis, and the symbiosis is not happy.

Case 4. Boy 5 years of age. Italian. No family history obtainable, though mother is noticed to have all the neck glands enlarged, and while we have had the boy under treatment she has had ptosis, and facial paresis. She will not permit examination. The child had a typical appearing knee with fever, night cries, tenderness and deformity. The diagnosis of tuberculosis had already been made, and we agreed without reservation. Later the child developed a large gumma above the sacro-iliac joint, and soon a second gumma in the right thigh. The boy was then given KI, and although he has not taken it regularly the lumbar gumma has disappeared, the knee has developed painless motion to half normal extent, while the thigh gumma is represented by three small loculi. In the interim the mother has had ptosis and facial paralysis which she has herself cured with an Italian medicine.

Case 5. Boy 6 years of age. Father died from what appeared to be specific cerebral disease. Last summer the child suddenly developed pain, lameness and spasm in the left hip with night cries. Because of the family history, and the sudden onset, he was given KI, and all symptoms cleared up within a month. During the last few weeks the child has had an attack of pain and tenderness in the right foot, which recovered in 10 days under similar treatment. These attacks could be taken for rheumatism, but in each instance there was no fever, no heart involve-

ment, and but a single joint, which rapidly cleared up under specific treatment. These points while not conclusive are suggestive.

Case 6. Girl baby, a few weeks old. She was seized suddenly with fever, pain, swelling and tenderness of the left hip. The swelling rapidly increased, and within a few days the femoral head was extruded. She recovered under gray powder and inunctions, and is at present about 16 years of age, in good health, but with a fairly typical facies of hereditary lues. Syphilis in parents was denied. The girl now has a strong leg, with almost normal motion, and a shortening of only 4 to 5 cm., a result hardly to be expected after epiphyseal destruction by tuberculosis or from a staphylococcus.

Why the limb growth is greater after the loss of an epiphysis by lues than after its destruction by tubercle, etc., we do not know, but it has appeared to be so, not alone in this case, and not only in the hip, but we have seen it also in the knee, and in the elbow. Whether the thickening and hypertrophy of the periosteum which so often characterizes syphilitic bone disease in later life, is also present in this fulminating expression of lues, and if so whether this periosteal overgrowth favors restitutio beyond what we find after other infections, we also do not know; but it seems probable, and would account for what we have various times observed, and cannot otherwise explain.

Case 7. Man 35 years of age, in second stage of lues, and while under treatment, is attacked with swelling, pain and loss of function in the hands, especially of the first metacarpo-phalangeal joint. Radiograms show an osteitis of the distal ends of all the metacarpals; also in the distal ends of many of the proximal phalanges. Pushing the mercury it got well, leaving practically no trace. This osteitis is frequent and is mistaken for rheumatism. It may be the only evident symptom of the noncontrol of the disease, and while it often clears up under vigorous treatment it may progress to great destruction of bone and much deformity.

Case 8. Young woman. Trained nurse with a left knee of 9 months standing, which was considered tuberculous. There was much thickening over the joint cavity, and considerable tenderness, especially at the joint line, but little or no pain except after use. No nocturnal pain. No deformity, except a moderate flexion from the tension. This absence of deformity after such a period would be rather an uncommon feature in tuberculosis, but failed to arouse suspicion. Opening the joint demonstrated a small oval area of tibial cartilage, and a small area on each condyle, peeping out from a gummatous mass which completely filled the joint. It had the appearance of a neoplasm and was evidently not tuberculous. It was now remembered that the girl had sparse hair, scant eyebrows and had given a history of sore throats. The knee was closed and as soon as practicable she was given anti-luetic remedies and recovered.

Such joints are not rare. We have recognized several since which have recovered under appropriate treatment, while we remember our failure to appreciate others in earlier years. One woman in particular had just such a knee, later an elbow and still later a shoulder. The attacks eventually receded, leaving definite damage in the first two joints, and considerable destruction in the shoulder. The etiology passed unsuspected by us, and apparently so by many other surgeons. She had lived

some years in South America and we freely confessed to her that we did not know the cause of her trouble, but suspected it was due to some uncommon infection contracted in South America. Experience, however, has taught us that while this particular patient perhaps contracted her disease below the equator, similar infections are not rare here.

Case 9. Man 35 years of age with definite luetic history. Suffered severe hardships during Russo-Japanese war. Feet gave out during severe march, and he has been crippled ever since. Clinically he had flat-foot of the type which one associates with gonorrhea. Radiograms, however, show nodes on the lower end of the tibia, on the astragalus and on the metacarpals, but no sign of the spur-like osteophyte seen in gonorrhea. The pain was relieved by large doses of KI, after which the usual treatment for flat-foot gave comfort and allowed the man to resume his work.

We have seen several such cases, one in a bar-keeper at present under observation in whom the diagnosis of lues was made from a radiogram of his feet. We are not to be understood as believing that any bone pain which is definitely relieved, or any joint pathology which is definitely cleared up by KI is *ipso dicta* syphilis, for we strongly hold that such result cannot be accepted as proof. We are in the habit of giving iodides to most patients with osteo-arthritis and we believe with benefit. KI also in ordinary doses often speedily relieves the pain of ordinary flat-foot and especially when redness and swelling accompany the pain. This relief can be expected when there can be no question of lues. The so-called "therapeutic test" proves nothing when no lesion characteristic of lues is present. The condition described in Case 9, is, however, quite typical. The periosteal and perichondrial nodes are characteristic and found, so far as we know, in no other disease. If the "therapeutic test" alone can be accepted, what is to be said of the following cases:

Case 10. This represents one of three cases which we have seen during the last 2 years and excepting for sex and some slight variance in age, one description answers for all. Girl 16 years of age. Some years ago she had the shaft of a long bone removed for osteomyelitis, due to the staphylococcus pyogenes aureus. She has since been subject to acute attacks of swelling of the shaft of a long bone (not of the bone which was resected) accompanied with excruciating pain and tenderness. The attack has usually been in the right humerus, though it has occurred in the left femur, and in the left humerus close to and perhaps involving the elbow. The swelling is deep seated, involves the whole circumference and does not affect the superficial structures. The tension is extreme. KI in large doses promptly relieves the pain and removes the swelling. Between attacks nothing is evident. In each case we know the whole family and have gone over the different members again and again and do not at present suspect lues as a cause.

Case 11. This represents another group of 3. Two are young adults of 16 to 18 years, and the third a man of 35. History negative for lues. In the two younger patients we have also examined both older and younger children in the family, as well as the parents, and have at present no suspicion of a syphilitic origin. The man's history (except that he has had a single attack, and the others 2 and 3 attacks) is typical of the group. After a blow on

the tibia the bone promptly became hot, swollen and tender and has so remained for nearly a year despite all kinds of treatment. Examination shows swelling on the tibia extending from the epiphyseal line downwards about 10 cm. It was softened in the centre and was periosteal in character. It was more tender than painful, and the pain was not particularly nocturnal. It entirely disappeared in three weeks under large doses of KI. Was this lues? There is no history—no other evidence. We would disregard this in a single case, but if so the younger patients should have shown something, or some slight stigma should be observed in some member of the family.

#### Discussion.

Dr. T. W. Huntington, San Francisco: There are two or three points which have suggested themselves to me during the reading of two of the papers, to which I want to call attention. I appreciate heartily the idea of the advocacy of early active treatment in the initial stage of the initial lesion. I know of no medical heresy which has given rise to so many unfortunate incidents as the teaching of ten or twenty years ago to the end that we should not begin our treatment until we have made our diagnosis. Others will bear out this statement. It seems to me, as in other things, the diagnosis can be made without waiting for the subsequent incidents in the progress of the disease. The second point is with regard to the close relationship existing between malignancy and the later stages of syphilis. Attention has been called by a number of authorities to the frequent grafting of cancer upon an old syphilitic lesion of the tongue. I have seen two or three such cases where cancer of the tongue is very clearly manifested upon the ground work laid by the syphilitic patient. This point also holds good with the rectum. These cases have been manifested in my experience. The final point is to give my approval to the idea that there is no such thing as radical cure for syphilis, when we hear that late symptoms appear as far after as 20, 30 and 40 years. The medical man should educate the people on this subject. It matters not that the prodrome seems to be clear. It matters not that the husband may live with the wife for many years without having the innocent person affected. The fact that the first person was attacked may give rise to symptoms at a late period. This point should be taught fully and completely.

Dr. W. T. Barry, Santa Barbara: I was especially interested in the paper which Dr. McBride read on cerebral syphilis. [Paper not received for publication—Ed.] I once knew a gentleman, some years back, who accidentally mentioned to me that he had an initial lesion. He did not mention this to me consulting me, but as an act of confidence, when in my office one day he showed me the lesion. It was a hard chancre. Some years after that I was requested to go to a certain city after this gentleman, who was in a state of insanity. I was told that he had been drinking hard and that something would have to be done with him. I went after him and persuaded him to return home with me to Chicago, and accidentally remembering the lesion which he had showed me I had the clew to this insanity. I gave him iodid of potash in enormous doses, and I had the pleasure of seeing that insanity clear up and his mind return to him perfectly. It was a beautiful exhibition of what iodid of potash will do. What has impressed me is the necessity for the general practitioner to assume the responsibility of warning his patients to leave alcohol alone. There is nothing more pitiful than to see a man of some prominence utterly lost and finally dying from the effects of this disease. I think the conscientious physician should caution all such cases. As Dr.



McBride says, these lesions come on ten, thirty and forty years after the initial trouble.

Dr. A. B. Grosse, San Francisco: The proposition is this. Just as soon as we are sure of our absolute diagnosis we can begin treatment for these cases. This is very simple. Any man who has the technic of finding the spirocheta can easily find them from the smear, and in many cases the primary ulcer may be removed. In my opinion, the spirocheta can be found in the section. The late work with the serum has shown the absolute result of the test of the serum, showing that upon the finding of the primary sore the reaction is absolute so that you can be sure of your diagnosis. The inunction treatment is the oldest and the best that can be satisfactorily carried out in most cases of syphilis. There are a number of cases where, for social reasons, this treatment can not be carried out. Most men, as well as many women, are ashamed to have the stain of their shame upon their body. The internal administration of the drug carried over a long period of time renders the system more liable to malignant disease. Now we are having demonstrations of the hypodermic injections of this drug. These are divided into the soluble and insoluble salts of the drug, and I agree that the bichloride is the simplest and the best. People are more willing to take this drug than they are to take the inunctions. There are certain people in whom there are infiltrations following the administration of this drug. Then we have the mild soluble salts. The salicylate of mercury is mildly soluble in the presence of a medium containing albumen. There are, unfortunately, infections in syphilis so rapid that we can not combat them. I can not strongly urge the use of calomel or gray oil. There is a tremendous oblique action to this drug and salivary poisoning.

Dr. E. E. Kelley, San Francisco: I wish to call attention to the treatment of cases of hereditary syphilis and its influence on intercurrent disease. I have under my care a family of children who have inherited syphilis. Only one child has shown any extreme manifestations of the disease. I have noticed that in the treatment of intercurrent diseases in this child, there always seems to be a decided aid in the control of it by the use of anti-syphilitic treatment. I think that every practitioner ought to bear this in mind in the treatment of these children who have inherited syphilis with other diseases. Another point is that many diseases not syphilitic will show decided improvement upon the use of iodid of potassium. So I believe that it is not always proper to say that because a disease gives in to this treatment that it is syphilis.

Dr. E. D. Chipman, San Francisco: There are several points in the treatment of this disease which are often overlooked and which may be of distinct value in the diagnosis of the disease. We all know how easy it is to overlook the primary lesion or even the secondary manifestations on the skin. We very often encounter the so-called syphilitic leukoderma which occurs upon the neck, which consists of plaques, round or circular, of deep pigment and hyperpigmented. This is not to be found with the usual skin manifestations which may occur on any part of the body. The leukoderma has special preference for the neck. Another point emphasizes the remark of Dr. Huntington, concerning the special ease with which malignant epithelioma affects the tongue of syphilitic subjects. There are some authors of Paris who strongly insist that all epitheliomata of the tongue are of syphilitic origin. It is certain that all epitheliomata of the tongue should always excite our suspicion.

Dr. M. Regensburger, San Francisco: The treatment of syphilis, if carried out in a certain routine without doubt will bring the patient into good con-

dition. The treatment should be begun as soon as the chancre is diagnosed. In secondary syphilis, I have been giving the pill 1/25 grain bichloride of mercury, 1/25 grain of opium, giving 3 pills three times a day. This is a clean treatment and causes no inconvenience. Sometimes the manifestations occur very rapidly. So far as the injections are concerned, you will find that you drive your patients away if you continue your injections. I very rarely give injections. The results with the pills are magnificent, and your patient is pleased with his medicine and with the treatment. In tertiary syphilis, I give the iodid of potassium, beginning with 20 grains and going up to 200 grains, increasing the dose every four or five days. I continue this for four or five months, and then cease and go back over the same ground. It is a simple treatment and you will get a good result.

Dr. F. M. Pottinger, Pasadena: I sometimes think that the medical profession should remember that rest plays a part with syphilis as well as tuberculosis. I have treated with interest these cases with tuberculosis. About two years ago a case was under my care with double involvement of the lung and also trouble with the larynx. I was convinced of the effect of rest on syphilis, and iodid having been used, I put the case on both iodine and tuberculin. Very soon the larynx healed and the patient was able to swallow. With my method of treatment, I have used especially a treatment called orthoform. I used this for a month and then let the patient rest. Then I treated her afterwards with tuberculin. Finally she left, with the pulmonary condition healed but the larynx not. She went back home to St. Louis and got worse, and one day she was taken with great pain in the larynx and sent for a physician in the neighborhood. He did not look into the larynx, but from her description gave her a prescription for iodid of soda and the effect was wonderful. In a short time her larynx was well and she was put on a combination of tuberculin and iodine, and in less than two months the expectoration and cough had disappeared. I have come to believe a great deal in the statement made by Stengle that there is a certain sign which seems to indicate inherited syphilis. This is difficult to describe. We find it in the middle and posterior lobes, between the scapulae. You have a feeling of a sort of ballooning up at the end of a deep breath. You get about the same sound if you put your head under water. Stengle says that when he finds that sign he always uses iodid, and I have followed it out with very good results. He thinks it is the effect of inherited syphilis. I think there is something in it, and I know that many cases have done splendidly when the iodid is given.

Dr. A. Hoisholt, Stockton: I just wish to say a few words with regard to the differential diagnosis of cerebral syphilis. Dr. McBride laid great stress on the apathy in that trouble. There was a time, perhaps, when general paresis was spoken of in classical form. It was more prevalent then than now. It is practically almost impossible to make a diagnosis between syphilis of the brain and general tabes or pseudo paralysis. It is a well-known fact that general paresis is met with in different forms. You have the so-called classical dementia form and the euphoria is present. I have seen cases where you would have some apathy exactly in general paresis as in syphilitic brain disease, and I think it is impossible to make a diagnosis from the mental symptoms from the way the ideas are expressed. The diagnosis must rest upon the whole picture, and especially upon the systemic symptoms and their development.

Dr. Jackson, Pasadena: I remember a case of congenital cerebral syphilis in a girl of 15. A practitioner had been watching the case for three weeks.

There had been great suffering from severe headaches, but the practitioner, who was a man of experience, turned the case over to me with only the suggestion that the age of puberty probably had something to do with the headaches. At my first visit I found her lying asleep in bed with the mouth open. I noticed immediately the Hutchinson teeth. With the history of three weeks' headaches, I made the diagnosis of cerebral syphilis. The practitioner who had been caring for the patient had not had that in mind. The father of this girl had been a graduate from Bellevue, but did not seem to recognize the condition present. She seemed better and I waited for 24 hours, and I thought that if she were still better I would not change the medicine. Twenty-four hours later when I went there, they said that she had been sleeping continuously and that they had not disturbed her. She had not urinated and the father seemed perfectly contented with the situation. I insisted upon seeing the patient and found an inter-cerebral hemorrhage, hemiplegia and aphasia. Upon further examination, I found the keratitis and the history brought out the fact that there had been an attack of keratitis when the child was five years old. Further examination showed a scar of the tibia. There was also an exudate. I gave iodid of potassium. The father told me that when the child had had the attack of keratitis, when five years, that the oculist had said that it was syphilis and that he had insisted that it was not. The aphasia practically disappeared and in about two weeks the second attack of atypical apoplexy with interference of the respiration came on. I know of another case of cerebral syphilis with headaches. The patient went to the drugstore and the medicine was used without effect. Careful examination of the urine showed diabetes and by exclusion I called it syphilis. For the sake of family relations, I could not tell the wife. I suggested a consultant but they did not want one. I told the patient that he might be worse, but could not be better before three days. He got better, and afterwards they telephoned to me and said they had sent for another doctor. This practitioner took care of the case from 1 until 7 the next afternoon without making a urinalysis, and the patient was unconscious, having convulsions and in a deep stupor. The other practitioner had taken him off the medicine he had been given.

Dr. C. M. Cooper, San Francisco: It seems to me that we should endeavor to carry away from such a meeting as this some of the principles underlying this subject, and I would venture to advance: 1. That many mistakes have been directly due to insufficient examination, physicians taking for granted the apparent. As an example, I will refer to a lady who has come under observation at three different periods of her history, the first time relative to an opinion concerning the treatment of a supposed recurrent epithelioma of the lower lip, the second time some two years later relative to a big tumor of the tongue, the third time a few months since because of large ulcerations on the soles of the feet. The supposed epithelioma had been removed by a surgeon of repute. The tongue was to be amputated by a well-known operator, and the ulcers had been treated in a sanitarium with all manner of electricity and wave light. On each occasion she bore on her person such definite evidences of syphilis as to have made the diagnosis patent to any one had he thoroughly examined her. 2. That syphilis is the arch imitator of all diseases, but just as a copy of a picture lacks some of the distinctive features of the original, so the imitation of syphilis is not absolutely true. Therefore, when we meet with diseased conditions which are atypical, let us think of syphilis. E.g., given a patent with a huge knobby liver, we naturally think of secondary carcinoma,

but if we find a history of 8 or 9 years we should suspect syphilis. Again, take a case of psoriasis, the patches presenting indurated edges, our minds again recognize the slight departure from the typical picture of psoriasis, and again we should think of syphilis. 3. Syphilis is a disease which shows itself by a multiplicity of lesions: Take, for example, syphilis of the nervous system, here brain and cord lesions occur together with comparative frequency, and such multiplicity of lesions should make us suspect syphilis. 4. When in doubt in cases of disease of the central nervous system, whether a lesion is syphilitic or functional, let us remember the value of a cytological examination of the fluid withdrawn by spinal puncture from the subarachnoid cavity. 5. In treatment, let us remember that we must be sure our patients are getting the mercury we prescribe. The mistakes I have made have been occasioned through believing unreliable patients. That many patients suffering from syphilis of the cardiovascular system should be put in bed whilst being treated, as mercury and potassium are depressants. That in cases of undoubted cerebral gummatous syphilis of unknown location where our medication is without result, and optic atrophy developing, let us remember the value of palliative decompression trephining.

Dr. A. F. Gillihan, Berkeley: For example of "once a syphilitic always a syphilitic," I can report a case of a young man in Edinborough, who had acquired syphilis and who went to one of the most prominent physicians of that town twenty-five years ago. He was under treatment for three years. Two years later he married that physician's daughter. Since then they have had two children, who are apparently perfectly healthy. About two years ago the man came down with a typical cerebral and spinal syphilis, which responds readily to inunctions and K. I. Within the last year, the wife, who had always been perfectly healthy, has come down with a trouble in the anterior mediastinum which responds to K. I. and to mercury, undoubtedly being gummata.

Dr. Benj. Swan, San Francisco: Some years ago I was in Portland and a surgeon there said to me, "Whenever I am in doubt, I always treat for syphilis." Some years ago a young couple were married in San Francisco. In due course of time I delivered the lady of a fine boy. Everything went on well, but when the child was 15 months old, after going through the teething, it began to cry at night. I stripped the child and examined it from head to foot, but could not find anything out of the way. The child persisted in crying at night and waked up the neighborhood. There was no sign of syphilis. I could not find the first indication and could not imagine what the trouble was. A few weeks after that the father came into my office, and asked me to look at his shin and there was the characteristic trouble. I asked him whether he had ever had syphilis, and he replied that he had had it four years ago but had gone through thorough treatment. I then immediately called upon the child again, and examined it from head to foot but could find nothing. I prescribed bichloride and iodid and in three days the child had stopped crying. I pushed that child on to adult doses, and had the satisfaction of seeing it never sick again with any trouble, and two years ago I attended his funeral at the age of 25. from acute pneumonia. When I first came to California I was very closely associated with Dr. Sawyer. He told me that I would find that people did not bear mercury as well here as in New York and that I would have to treat with tonics. That has been my experience, and I found that you just have to crowd your tonic treatment.

Dr. Chas. Levison, San Francisco: There was one point brought out by Dr. Cooper with regard to

the palliative trephining. This, I think, is one of the most important factors in the treatment of a focal cerebral syphilis. Many of us have had the experience of the treatment of cerebral syphilis and making the diagnosis on account of the previous history, have administered large doses of mercury and iodid of potash without any apparent result, having the case go on to a fibrous gumma with the resulting condition which is impossible to remedy. Palliative trephining can be done if we have anything like focal manifestations. I have seen Sir Victor Horsley do this operation and mercurialize the brain with a solution of 1/100 bichloride of mercury, a procedure most astonishing, and is able to do this procedure without any apparent trouble. The trephining is a comparatively simple matter, and he seems to handle the brain without injury to the patient.

Dr. A. S. Lobinger, Los Angeles: In the differentiation of syphilis from carcinoma, which is a most important one in the involvement of the tongue, I think too great care can not be shown. Many of these cases have come to the surgeon with a diagnosis of carcinoma when the case has shown, on further examination and development, to have been one of tertiary syphilis. It is a very serious thing to remove the tongue or do any operation on it unless there is a very good reason for it and unless there is certain malignant involvement. I was much impressed with the remarks made by Dr. Cooper. The failure in the treatment of syphilis and in the diagnosis has risen in the majority of instances from carelessness or indifference on the part of the patient, especially in following out the treatment, also on the part of the physician in not having exacted that discipline and persuasion which is necessary to obtain the result. The last speaker mentioned Sir Victor Horsley and his work. I am sure that that is a great field, and I have talked with Horsley many times about the treatment of gummatous growths in the cerebrum where the pressure symptoms were so marked that there was not time to make a differential diagnosis. He reported to me most astonishing results obtained by trephining and making the osteoplastic flap. These cases are very important from the standpoint of the immense relief that can be given in a case of thrombus destined to be fatal. I have seen cases of gummatous development in which it was absolutely impossible to differentiate, except as revealed at post-mortem, between the diagnosis of sarcoma or glioma and that of gummatous growths. I have seen as much as 600 grains of iodide of potash given in 24 hours without the slightest result. The pathological examination proved it to be gummatous tumor. Such a case as that has been reported by J. T. Eskay. He emphasizes the fact that in those cases you can not give too much care to them. Leukoplakia is not necessarily an evidence of syphilis. When it is found in conjunction with the other manifestations it may be depended upon. Yet I have observed it as a later manifestation and one in which the diagnosis should have been made from the other symptoms much more than from the leukoplakia itself. I believe that leukoplakia, if found in conjunction with the development of the tumor of the middle or dorsum of the tongue, may be almost pathognomonic. It may be that it represents that intermediate stage from a syphilitic stage instead of carcinoma. The treatment should be instituted long before this development.

Dr. Geo. Cole, Los Angeles: This subject has been very well covered and has been very interesting. There was one point which was hardly emphasized enough. That is in the treatment of syphilis, speaking from the standpoint of the general practitioner, that we must individualize our cases. All cases of syphilis can not be treated alike

or with the same amount of mercury or potassium iodide. There is the general impression that as soon as we have diagnosed our case that the patient must have all of the mercury and iodide we can possibly get into the system. We should be careful and not overdo the thing. There are many cases that are overtreated. They are given too much mercury and too much iodide of potash. We should remember that the proper treatment for syphilis is the tonic treatment, and when we give iodide or mercury to the point that the patient becomes depressed, we should lessen the dose.

Dr. Stanley Stillman, San Francisco: It seems to me almost presumptuous to speak of the necessity or advantage of diagnosis, or of careful attention to the diagnostic point as between syphilis and malignant disease. The point has been made over and over again. My experience has been at variance with most of the speakers in that I have had experience with a number of cases in which the diagnosis had been syphilis when it should have been malignancy and where, if there had been anything like a careful examination, syphilis would have been eliminated. Cancer of the lip occurring in young men 24 and 36 years of age is not uncommon. I have had 6 or 7 such cases, who had been treated with anti-syphilitic treatment until the time had gone when the surgeon could have done any good, because malignant disease is so rapid in these cases. Also with regard to leukoplakia, I have seen many cases of epithelioma of the tongue and of the mouth, of the buccal cavity and cheeks and gums, developing on the site of an old leukoplakia and in patients in whom syphilitic origin was out of the question. One man died a few months ago having been under observation four times, operated upon three times for recurrent carcinoma of the mouth. He was the father of a large family and died at the age of 85, having been a very healthy man except for the malignant disease. I have in mind an old friend of mine, who consulted me for 8 or 10 years before the malignancy developed on this base, in which there was no thought of syphilis, either with himself or anywhere in the family. If one can live with syphilis to 60 and 80 years of age, it is a peculiar thing. These are the points of which I wished to speak because they are at variance with what has been said.

Dr. A. W. Morton, San Francisco: I wish to report one case under my observation during this month. The man is an attorney of prominence, who developed syphilis last year. On the 7th of January the left facial nerve became paralyzed and there was evidence of gumma in the brain. He had been taking enormous doses of mercury and iodide of potash. Last month he spent most of the time at some southern resort and continued the mercury. On the 7th of this month he called at my office, and on examination I found a complete paralysis of the left facial, so much so that it was with great difficulty that the man could talk. He had not been able to close his left eye since the paralysis had originally occurred. I placed him on large doses of bichloride of mercury intravenously, because I wanted a rapid action. On the third day, after looking up some of the works of Bier, I decided to produce an intense hyperemia in the brain for one hour night and morning. The first time I placed the compresses over the jugulars, bandaged and kept this on for an hour. In the evening he called my attention to the fact that he closed his eye. The improvement increased and he could whistle and had perfect control of the left side of the face. I attributed this to the mercury, but the next morning he returned and told me that after he had gone out into the air the night before the paralysis had returned and he wanted me to put the bandage on again. I applied the bandage again and at the end of an hour he had perfect use of the



face, so much so that he used the muscles in every way except that the muscles were slightly atrophied. After making this observation, I had him come to the office in the evening and at the end of the application he had perfect control of his muscles. This went on and on the 16th of this month he had perfect control of his face and returned to me after a week with all the paralysis disappeared. That to me was something that I could hardly attribute to the hyperemia, and still the evidence was so complete that I could not doubt it. A number of physicians watched this case with me and saw the paralysis disappear. I thought that it might be hysteria, but there was no evidence of it. This case brings up the value of Bier's treatment, of which I shall speak later.

Dr. H. G. Thomas, Oakland: If there were 2,000 physicians here, I would ask you what proportion of the medical profession recognizes, or examines, and really finds his syphilitic cases? As Dr. Cooper has said, syphilis is an arch-imitator of all diseases. I think the role of the oculist and aurist, with regard to this disease, is that of the diagnostician. We look at this disease with interest until the lesion in our line, which we are helping, has disappeared. I believe that is the trouble with syphilis all over the world. The lesion is treated and not the disease. What can we say of such a physician who has had charge of a family for years and has not recognized syphilis? As to the treatment, I think that the best treatment is looking after the patient and keeping your finger on the pulse of the treatment. If you give your patient iodide of potash or pills, how long will he keep up the treatment, and do you know whether he is keeping it up or not? Have you control of your patient? Your cases will get better ten times as fast if you look after them carefully.

Dr. Granville McGowan, Los Angeles: It really makes but little difference what form of mercury is used. The essential treatment is to prevent the development of the spirochetæ. I think that in the discovery of the spirochetæ we have found the cause of syphilis, that it is the micro-organism itself. I also believe that in making the diagnosis of syphilis a great many mistakes will be made based upon the question of the spirochetæ. There will be many errors, but this opens a way to better diagnosis of early syphilis. We know that the agent which controls syphilis is mercury, associated with anything that will control the general quality of the blood and increase the number of red blood corpuscles. I deprecate the use of opium with mercury. It is not necessary for physicians to put that extra temptation before these patients. In the use of the salt of mercury, I do not deem it necessary to ever produce salivation, however grave the case may be. Intestinal disturbances or the appearance of globules at the edge of the gums should be the signal for the lessening of the adult dose. There should be perfect cleanliness of the mouth and the use of chloride of potash tooth paste. Whatever the salt used, the essential point should be a dose sufficient to improve the symptoms of the disease.

### THE EARLY RECOGNITION AND TREATMENT OF SQUINT.\*

By WM. F. BLAKE, M. D., San Francisco.

The subject of squint or cross-eyes is one that should strongly interest the general and family practitioner, and I hope that what little I may have here to offer on this subject may reach the ears of those for whom it is primarily intended.

It is to the family physician that the child is usually taken when the early transitory deviations

of the eyes begin to appear. On his judgment the parents rely, and his advice, right or wrong, is in most instances unhesitatingly followed. I am glad to say that, as a body, physicians not specialists in the treatment of the eye have a right appreciation of the importance of the very earliest possible treatment of these cases. This means that at present fewer and fewer children subject to this defect are allowed to drift on until the deviating eye is fixed in its deformity, and blind as a result of disuse.

In this paper I shall confine my remarks on the subject of squint to the convergent type of variation, as this type is more common and perhaps more easily recognized. Though much that follows as to etiology and more particularly as to treatment is equally applicable to all heterophorias.

Squint was originally defined, and unfortunately this definition is still widely accepted, as a deviation of the visual axis of one eye from the correct position of fixation. This definition, true as far as it goes, stops far short of the whole truth. As Worth well says, "One might as well describe Potts' disease as a deviation of the spine from its normal shape." The deviation of the eye is only the external sign of the trouble, a symptom whose importance has been allowed to overshadow the true picture.

True parallelism of the eyes is, if not rare, at least not frequent. Yet only a very small percentage of these imperfectly adjusted eyes retrogress into a condition of fixed deviation. There is in the brain a center whose function is to receive and blend the double picture of external objects that come to us through the two eyes. If through anatomical anomalies of the orbit, or faulty muscular insertion of the extrinsic muscles of the eye, or unequal or faulty innervation of these muscles, the eyes do not naturally assume a correct position for the binocular impression of external objects, then the higher perceptive center, commonly called a fusion center, in accordance with the law of corresponding retinal points, sends out afferent impulses to the motor nerves of the eye, thus prompting more accurate adjustment of the optic axes, and makes possible the blending in the mind of a clear-cut picture of the binocular recognition of an external object. Thus the fusion center, through its desire for single binocular vision, demands accurate adjustment of the optic axes. It is the defect or abeyance of this faculty of fusion that allows the original slight imperfections of adjustment to progress into a fixed deviation of the visual axes.

Another condition associated with squint is suppression of vision in the non-fixing or deviating eye and as a corollary of this suppression, progressive central amblyopia. There is usually associated with convergent squint some error of refraction, most frequently hypermetropia and hypermetropic astigmatism.

Congenital amblyopia is admittedly a clinical fact, though it is certainly a much rarer disease than was formerly believed. If congenital blindness be present, it is undoubtedly a factor in the production of squint, since then there are no efferent impulses going from this eye to the brain and no afferent

\* To have been read at the Thirty-eighth Annual Meeting of the State Society, Coronado, April, 1908.

impulses returning to keep it in alignment with its fellow. It is thus left to the play of its extrinsic muscles and turns in the direction of the strongest pull. Happily our original inference as to the etiology of squint, that it was due to a congenital amblyopia has been superseded by the scientifically established fact that the amblyopia is one of disuse—an exonopsia that follows progressively and proportionately the mental suppression of the image in the deviating eye and the lapse of months or years over which suppression existed.

There has always been in medicine a warfare between science and empiricism—nowhere more true than in the pathology and treatment of squint. A fundamental mistake has been to look upon a squint as a deformity of ocular muscles, a mechanical displacement, a supposed shortening of one extrinsic muscle, hence how natural the empirical treatment of tenotomy or myotomy as originally done by Dieffenbach, the father of this muscular theory. Since the appearance of Dieffenbach in 1840, before the French Academy of Medicine, there have been many and enthusiastic advocates of his theory and treatment. In spite of the brilliancy of technic of these operators, results have often been disappointing, if not disastrous, such as strabismus of the opposite type, retraction of the caruncle and exophthalmus.

With Donders began a new era—he grounded his plan of treatment on a physiological basis and established the theory of the relationship between convergence and accommodation.

It one looks at a distant object, as a mail box on a corner a square away, the axes of the two eyes are parallel, and if the eyes are emmetropic, rays of light from the distant object come accurately to a point on the retina. If the eyes be hypermetropic then they must accommodate, that is, increase their refractive power by contraction of the ciliary muscle. If the point of regard be now shifted from the distant object to the point of a pencil held a few inches in front of the nose, then the eyes must be rotated inward, i. e., converged, and in order that the now divergent rays may be brought to a focus on the retina it is necessary for the ciliary muscle to still further contract to increase the lens' refractive power. Thus we see that the act of convergence and accommodation are physiologically associated.

Donders first recognized this relationship and by its application to the treatment of squint, he began the salvage of this branch of ophthalmology from the grasp of empiricism and put it in the sane and safe custody of science. Donders saw that if there is a relationship between accommodation and convergence whose standard ratio is found in emmetropia, then in hypermetropia with its added burden of ciliary activity and constantly increased nerve impulse, there follows also to the functionally related phenomenon of convergence an increase and an overstimulation to the internal recti muscles. This upsets the relationship of diopters of accommodation to the prism angles of convergence, convergence is over stimulated and one or the other eye, that one in which the overstimulation is greater, places its line of vision to intersect a point nearer

to the face than that at which the object really exists.

While the theory of Donders is fascinating and scientifically sound as far as it goes, it stops short of a perfectly satisfactory explanation of the etiology of squint. It is a well recognized fact that only a very small percentage of hypermetropes become squinters; and more, it is not necessarily among the high hypermetropes where the balance between accommodation and convergence is most disproportionate that the most and more pronounced cases of squint are found.

It remained for Javal and Paunard of France, Worth, Maddox, Priestly Smith in England, and in this country Savage, Reber Vierhooff, Duane and others to recognize the influence of the higher brain centers and to show that the power of fusion is the governing factor in stereoscopic vision.

Since the field of fixation of each eye overlaps to the extent of 60° the nasal field of its fellow, it follows that the image of the object looked at is formed on each fovea. Yet though there are two images, we see not two objects, but one. In other words, we have binocular single vision. This phenomenon of combining the two retinal images into one is executed in the mind by a higher center called the fusion center. Vision with two eyes is more distinct and the object more solid looking than when seen with one, in the former instance we get clear, in the latter imperfect ideas of distance, depth and relief.

Over this mental process by which the blending of duplicate images is accomplished presides the fusion faculty. The absence or non-development of this center appears to be the prime factor in the production of squint. Interesting as is the discussion of the causes and production of squint, it is to a discussion of its recognition and treatment that the mind insistently turns.

While the family practitioner is not in a position to undertake the treatment of these cases, he can, as general adviser to the family, urge upon the parents the proper course to pursue. Unfortunately for the child, parents sometimes postpone treatment on the assurance that the child will outgrow the trouble. It is true that an occasional crossed eye becomes straight. This can probably be accounted for by the fact that coincident with the growth of the child up to a time of puberty the outlines of the face change markedly and the axes of the orbit swing a little temporal-ward. But for the fortunate one eye thus happily made straight there are an host that steadily progress from bad to worse, later to become a living reproach to procrastinating parents, and to the medical profession an embarrassing unworthy example of its unwisdom or indifference. It is a matter of experience in the treatment of these cases of convergent squint that if seen early from 40 per cent to 70 per cent can be cured without any treatment other than the constant wearing of perfectly fitted glasses. No child that squints is too young to wear glasses and it is imperative that the refractive error be early corrected.

I have grouped the steps in the treatment of these

cases into six divisions, placing them in what I consider the order of importance.

1st. Accurate measurement of refraction under atropine. This, of course, presupposes expertness in the use of the retinoscope, this being the only means at our command for use in young children.

2d. Constant wearing of the full refractive correction.

3d. Occlusion of the good or fixing eye. This may be accomplished by the use of atropine, or, a method which I prefer, by taking a pair of light automobile goggles and putting a ground or black glass in front of the good eye with the proper correcting lens mounted in front of the squinting eye. The child is prevented from looking over or to the side of the occluded glass by coating the wire sieve framework with shellac. A few pinholes must be punched through for ventilation purposes. Vision in the squinting eye will improve much more rapidly if we make no compromises with the child or with indulgent parents, but firmly insist that these glasses be worn constantly.

4th. The use of the amblyoscope of Claud Worth. I use the modification of the original make suggested by Black of Milwaukee. I would here urge the unwisdom of allowing parents to undertake these exercises at home, for invariably they fail to execute them properly. The results are nil, and by the fruits of their own efforts they are likely to estimate the good that follows as a reward of effort in more skillful hands. When by the use of the amblyoscope I have first stimulated simultaneous muscular perception, from this point progressed to the fusion of the two halves of a picture into a composite one, and so elicited a feeble sense of perspective, and if in addition to this I can by use of the cover test or with red or green glass in front of the eyes elicit diplopia, I feel that the case is well in hand, and with the co-operation of the child's parents I can almost certainly promise an ultimate cure.

5th. In the further treatment of these cases, I urge that the child be taught simple perspective drawing and that the child practice mental drawing of geometrical figures. This is an exercise that is frequently done in beginning art classes. Take some solid geometrical figure, as a cube, pyramid, rectangle, etc., put the figure on a chair or table some distance from the child, have him take a pencil in hand and trace out in space in front of him the directions of the lines and planes that make up the figure, doing this first with the right and then with the left hand. I have never seen this particular exercise mentioned in any text book or monograph on the treatment of squint, but I presume, though unmentioned, it is commonly used.

6th. The sixth and last step in the treatment of squint is the operative interference. This has purposely been placed last because a majority of cases can be cured without the aid of surgery, and it is sensible that this step be postponed until all other means fail. I do not in the least underrate the merit of muscular correction in the properly selected cases. To be a bit paradoxical, these selected cases

are those never selected for any kind of treatment, they are the result of someone's indifference or blunder. The eye is already blind from disuse, hence the prescribing of glasses to correct the refractive error and the effort to stimulate muscular perception are alike useless. In these cases surgery is of avail, yet even here it has its limitations. The most fortunate result is only a cosmetic one and even if happily the eye is put straight, and yet more happily, if, in the absence of vision, it remains so, after all the eye is as blind as ever and as useless as before the deformity was corrected. Abnormalities in the orbits and in muscular origin and insertion most certainly exist, and in these cases it will ultimately be necessary to operate to obtain desired results. But even in these cases means must be first taken to conserve good vision in the squinting eye and fusion must be awakened and stimulated to the maximum. When it is proved that the desire for fusion and binocular vision can not overcome the anatomical defect then we may wisely consider the advisability of operative interference, for with the visual function and fusion in the amblyoscope well established, we can rest in the assurance that nature will come to our aid. If now we more or less satisfactorily correct the deviation, nature will begin where the surgeon leaves off, and by its insistence on the stimulation of corresponding retinal points bring the eyes into perfect parallelism.

#### SOME THINGS TO REMEMBER.

The State Journal and the State Society have now offices in the Butler Building, Geary and Stockton Streets, San Francisco.

The State Medical Society meets in San Jose, April 20, 21 and 22, 1909.

The A. M. A. meets in Atlantic City, June 8-11, 1909.

#### SAN JOAQUIN COUNTY ON NOSTRUMS.

Stockton, Cal., September, 1908.

To the Physicians and Surgeons of San Joaquin County:

Dear Doctors—There has been a special committee appointed by the San Joaquin County Medical Society to look into the abuses arising out of the use of proprietary medicines. These abuses are many and affect not only the physician, but the druggist and people at large as well. They affect the doctor in many ways.

First. He becomes lazy as to prescribing the medicines according to the national formulary.

Second. He compels the druggist to load his shelves with a lot of medicines easily compounded by any intelligent pharmacist.

Third. The druggist having these articles on his shelves, it is easy, in many instances, to prescribe over the counter to many people who would otherwise consult the doctor.

Fourth. An intelligent person who reads the prescriptions the doctor writes before presenting them to the druggist for filling, in many instances, become familiar with the name of this special preparation prescribed, and instead of handing in his prescription, will ask for this preparation of the druggist, thereby getting the original package containing all the literature, dosage and other information connected with the medicine.

Fifth. The doctor, in his effort to dispose of these preparations, becomes an active selling agent for the proprietary medicine concern, and while it reduces his own profits in the business, aids these people to



make tremendous fortunes and encourages them to further foist upon the public more and more nostrums.

The duties of this committee are to recommend to the society and physicians at large, the best method of prohibiting the use of these preparations. The committee also desires an opinion from every physician in San Joaquin County and to this end has prepared a series of questions, which should be answered as promptly as possible.

It is not possible nor practical for each of us to analyze each preparation pharmaceutically; consequently we have in the past been compelled to accept the manufacturers' word for their formulas, but such is no longer the case since the Council of Pharmacy of the A. M. A. has carefully and scientifically done that work for us.

We have taken up this matter with a number of first-class pharmacists. They are only too anxious to assist us (and themselves) by not having to carry the tremendous number of proprietary drugs which we order.

The national formulary contains everything in the way of medicines for internal and external use that we may require.

It is our object first to agree amongst ourselves to use nothing that is not sanctioned by the national formulary and the new preparations sanctioned by the committee on pharmacy of the A. M. A. If we do not use these proprietary medicines, the druggist will get rid of what he has, and will never buy any more. Should he do so, we can largely curtail his business by sending our prescriptions to the druggist who does a strictly prescription business, and if there are no concerns carrying proprietary medicines, the public will be largely protected by their inability to purchase them.

We are inclosing you a reprint of "The American Medical Journal" showing how ridiculously we have been imposed upon by the proprietary medicine fakers. We ask you to carefully read this reprint from end to end, and if you can not agree with us after reading this booklet, we certainly do not know any argument that will convince you, but we believe you are with us.

The page containing the questions we ask you to fill out and mail to us at your earliest convenience. We have other work to follow, and we desire to see the medical profession in San Joaquin County on the top notch of strictly ethical business in the near future.

Signed,

H. N. CROSS, M. D.,  
J. P. HULL, M. D.,  
A. M. TOWER, M. D.,  
L. WELTI, M. D.,  
B. F. WALKER, M. D., Secretary.

1. Do not the various text-books on therapeutics contain all the drugs and chemicals known to medical science?

2. Are you familiar with the principal ones of merit, and do you know their therapeutic action and doses?

3. Can you with your present knowledge of pharmacy write a prescription containing anything you desire?

4. If so, why don't you?

5. When you prescribe proprietary preparations do you remember all the ingredients they contain?

6. Does the majority of the pharmaceutical houses give you the quantity of each ingredient?

7. What can you tell your patient if he asks you if he may double the dose?

8. Is it not the physician's fault that proprietary remedies are kept in stock at all drug stores?

9. Is it not a fact that the druggist would be glad if the physicians did not use proprietary remedies?

10. Is it not a fact that druggists counter prescribe?

11. Is it not a fact that in most of the counter prescribing proprietary articles are used?

12. Would not the counter prescribing be less if there were no proprietary articles on the druggist's shelves to be dumped into bottles and labeled?

13. Does not a physician's knowledge of therapy become less after using proprietary articles for ten or twenty years?

14. Do you know your pharmacist makes less profit when you prescribe proprietary articles?

15. Do you know it costs your patient more money?

16. Is it not a fact most of the proprietary articles are made in the East?

17. Granting the above facts that the druggist makes less and the patient pays more, is it not a fact the patient's money goes to Eastern cities?

18. Do you honestly believe that you cure your patient more rapidly by using proprietary articles than Dr. B, who uses straight drugs?

19. Read the following facts before answering question 20: Gude's Pepto Mangan costs \$10.00 per doz. bottles (14-oz. bottles). Traces of manganese are found in the red blood corpuscles, but same is found to be unaltered in all forms of chlorosis or anaemia. (Steven's Therapeutics, page 242.) Numerous tests have been made by scientific observers in anaemia with Gude's Pepto Mangan and Bland's pill with the following results: Bland's pill did in forty days what it took Gude's Pepto Mangan seventy-five and eighty days to do. What is true of this preparation is also true of ninety-nine out of every hundred proprietary medicines.

20. Why do you use them?

#### BERI-BERI.

(Concluded from Page 358.)

The autopsy demonstrates clearly that death was due to an affection of the nervous system, especially of the peripheral nerves, which are the seat of true polyneuritis. This is especially pronounced in the spinal nerves; of the cranial nerves only the pneumogastric is involved, in certain cases, equally affected. In fact even the spinal cord is not exempt from the process of degeneration.

Chickens fed on rice not, or badly thrashed, never contract the polyneuritis in question; chickens attacked by the disease recover when the ordinary table rice is replaced by unshelled or badly thrashed rice or by husked rice which is added to their ordinary fare.

Eykmann is led to believe that the poison which produces the polyneuritis is not to be found in the fecula of rice. He is of the opinion that the poison is produced in the digestive tract through the influence exercised by the intestinal organisms upon this food. The pellicle or bran of the rice would thus have the remarkable property of rendering the poison inoffensive.

An investigation made in various prisons in Java seems to establish the theory of Eykmann. Thus the morbidity was 284 per 10,000 in the prisons where white rice was used, and was only 1 per 10,000 in the prisons where the base of alimentation was red rice.

The cause is insufficient nitrogen. Rice is the poorest of all the cereals in nitrogenous principles and according to Boussingault it does not contain any more nitrogen than hay; 100 grams of rice contain about 1.40 gms. of nitrogen. A ration of rice of 900 grams represents, therefore, 12.60 grams of nitrogen, although the ration should contain, according to physiologists, 20 gms. The small quantity of salted fish allotted to each individual is not sufficient to bring the nitrogen up to the physiological figure. There is, therefore, insufficient nitrogen in the dietary of the natives, which it is necessary to remedy by giving a certain quantity of meat.

The cause is insufficient fat. The working ration, according to physiologists, should contain about 60 gms. of fat; but on determining the quantity of fat contained in the alimentary ration of a prisoner at Poulo-Condor, it was found to be less than 20 gms. per day, a quantity notoriously insufficient, not only for work but also to sustain life. This lack of fatty materials in the dietary of the natives is, according to Bremaud, the true cause of beri-beri. Laurent has recently cited two epidemics of beri-beri; one at Chantaboun, the other at Poulo-Condor, where the addition of fatty materials to the dietary seemed to stop the disease.

The agents of the propagation of beri-beri are cockroaches. A Dutch physician has advanced the idea that cockroaches or weavils might be the agents of propagation of the beri-beri virus. The following would be, according to this author, the pathological physiology of beri-beri and the mechanism of contagion: The disease would be due to a specific microbe, which after penetrating the intestine and by its multiplication in the intestinal canal would produce a toxin the absorption of which gives rise to the beri-beric syndrome. The cockroaches serve to carry the specific organism from the feces of the patients to food, particularly rice, destined for healthy persons.

**Conclusions to be Drawn.**—Beri-beri seems to arise among human beings whose alimentation is defective. We have had occasion to assist during the epidemic of beri-beri in the jail of Poulo-Condor in 1880 and 1881. The epidemic ceased by the administration to the Annamite prisoners of a small portion of fresh fish every day. Beri-beri is thus like scorbutus, but it should be acknowledged that we have not penetrated the mystery of the genesis of either one.

**Contagion.**—Beri-beri is not a contagious disease. The epidemic arises always in a group of people who live under defective alimentary conditions and is not carried from one group to another living under good hygienic conditions, even though there be frequent communication between the two groups as is inevitable on shipboard. The epidemics of groups and of families should not be considered as examples of contagion, for if we determine the source we find that it is always the same, defective alimentation. In the case of the "Parmentier" which we have cited above, we have omitted mention of the epidemic of cholera which appeared on board after putting in to Mauritius. Cholera attacked the European crew while beri-beri attacked only the coolies.

**Predisposing Causes.**—(a) Age. Beri-beri, which is rare in infancy, more frequent in old age, reaches its maximum of intensity at the prime of life.

(b) Sex. Beri-beri is rare among women (1 to 15 according to the Japanese statistics) except during

pregnancy and after delivery. The wet form is more frequent in pregnant women than is the paralytic form.

(c) Race. The yellow and black races present a great predisposition for beri-beri. The white race is usually not attacked, but the immunity of the whites depends on their alimentary regime rather than on a true racial immunity, for in Brazil there have been observed a number of cases of beri-beri among whites and half-castes.

(d) Season. In Japan, according to Simonds, beri-beri occurs more often in winter. At Poulo-Condor, according to Gayet, the disease appeared always during the northeast monsoon, which is cold and wet (November, December, January). He has also observed it during the southeast monsoon among men working in the forests, which are cold and wet.

(e) Diseases. All the cachectic maladies predispose to beri-beri, especially malaria, dysentery, diarrhea and Bright's disease. Reaucar has remarked that the Annamites who have ulcers on their lower limbs are especially apt to have the disease.

**Clinical Study.**—Beri-beri presents three clinical forms: a wet form, beri-beri hydrops, characterized by edema; a dry form, paralytic or atrophic beri-beri; and a mixed form. But whatever may be the form of the disease, it is almost always preceded by certain morbid phenomena, as weakness of the lower limbs, dyspnea, a sensation of constriction at the base of the thorax, and unfitness for work. Rarely the infection begins abruptly with edema or paralysis.

**Wet Beri-beri.**—The edema begins always in the lower limbs and it is at the level of the internal surface of the tibia that it is most easily perceptible. It may next manifest itself on the face or the sternum and finally invade all the cellular tissue more or less rapidly. On this account arises the necessity of considering it under two heads, the rapid form and the slow form.

**Rapid Form.** In the beginning the patient is not able to assume the erect position, he falls when he attempts to rise alone. He complains of variable pains in the lower limbs. Sometimes these are like formication, sometimes pricking or stabbing. The edema makes rapid progress and the patient is soon infiltrated in all parts as in acute nephritis, but here the edema is more severe and the scrotum is not always attacked. Further, the urine does not contain albumen and shows a high proportion of phosphates.

Three other important symptoms accompany this general dropsy. They are constriction of the thorax, dyspnea and vomiting. The patient complains of a very painful sensation of constriction at the level of the epigastrium and the base of the thorax. This sensation, which is called the "beri-beri corset," is sometimes accompanied by a true angina. The patient may complain of an acute pain beneath the sternum. This is the sign of a serous extravasation into the pericardium. The dyspnea is sometimes so intense that the patient cannot assume the dorsal decubitus. Finally, vomiting supervenes and the gastric intolerance is such that the ingestion of more than a small quantity of liquid is impossible. The pulse is rapid and filiform, the heart-beats are softened, the rhythm fetal. There is sometimes reduplication of the second sound (De Lacerda). The interference of respiration may become so great that the patient literally dies of asphyxiation.

Sometimes the edema is not pronounced and nothing prevents the rapid progress of the disease, the patient dying rapidly of a syncope. We have observed a fulminant case of this sort in Poulo-Condor. It occurred in an Annamite who came complaining of weakness of the lower limbs. He

presented shin edema and as we were then in the midst of an epidemic of beri-beri I directed him to the hospital some twenty meters distant. He fell dead while walking there.

**Slow Form.** Here the serous infiltration does not progress so rapidly as we have observed in the first case. It progressively invades the tissues one by one. The face is puffed, the eyelids are swollen by edema, and Francois speaks of a patient who, in order to see, was obliged to open the eyelids with his fingers. The epigastric pain is less severe and the thoracic constriction less pronounced. When the termination is going to be fatal, the paralysis spreads, invading sometimes the respiratory muscles. Laurent has seen in four fatal cases phrenic paralysis manifest itself in the diaphragm by inversion of the respiratory rhythm.

In the case of termination in recovery, the anasarca disappears little by little, the tissues becoming normal. The patient may raise himself, but there remains for some time great weakness of the lower limbs. Before, as after the edematous infiltration, the limbs are very weak, to which the name of "glass legs" has been given. This feebleness of the limbs forces the beri-beri patient to walk with the legs spread apart and to use a cane which he carries before him. I call this beri-beri gait the tripod gait, because the limbs of the patient and the staff form a true tripod, which acts as a base to sustain the body. To advance, the patient moves successively each of the three branches.

Gayet has pointed out the existence of two painful points on pressure of the spinal apophyses; a first point at the level of the cervical enlargement of the spinal cord, that is to say, at the level of the second and third dorsal vertebrae; a second point more constant corresponds to the lumbar enlargement, that is, between the ninth and eleventh dorsal vertebrae.

**Dry or Paralytic Beri-beri.**—According to Simonds, the first symptom which appears after the troubles of the prodromal period is, in general, anesthesia of the skin in certain regions of the body, as the anterior tibial region, the dorsal surface of the foot, the ends of the fingers and toes and the circumference of the mouth. The patient complains at the same time of subjective sensations, formication, prickings and burnings. The gustatory mucous membrane is sometimes the seat of bizarre sensations. Costa Alvarenga has reported that many patients think they feel hairs and living creatures when they pass the point of the tongue over the palate (Gayet). The paralysis appears next in variable degrees in certain groups of muscles, usually in those which are situated beneath the anesthetic skin. The paralytic form which one sees commonly is pseudo-tabetic, and this has been called beri-beric pseudo-tabes. According to Alfredo Britto, the paralysis is preceded here as in true tabes by the signs which Fournier has noted in the preataxic period of locomotor ataxia, Westphal's sign, Romberg's sign, etc. In the anesthetic period the patients drag the limbs in walking as if they were in water up to their knees, but if the paralysis has attacked the peronei and anterior tibials, there is steppage gait as in true tabes.

The paralyzed muscles are always painful on pressure (Myodynia). Sometimes there are true lightning pains (Bourat). Sometimes the paralysis attacks the entire lower limbs, but it almost always respects the vesical and anal sphincters. We have, however, observed paralysis of both sphincters in a fatal case of beri-beri. Erection is difficult and slow at the beginning of the disease, later it disappears completely.

Sometimes the polyneuritis attacks the upper limbs. It manifests itself first by disturbances of the cutaneous sensibility, later it attacks the muscles. It attacks by preference the extensor muscles and

the inter-ossei muscles of the hand, giving predominance to the flexors, which sometimes become permanently contracted, producing the main en griffe or griffe beri-berique. These paralyzes of the upper limbs are frequently accompanied by trophic disturbances. These are muscular atrophy of the thenar and hypo-thenar eminences, drying of the skin, etc.

In certain rare cases, one observes anesthetic plaques on the face, the back and the abdomen.

In paralytic beri-beri, the constriction pains of the thorax are less pronounced than in hydropic beri-beri. According to Lacerda, pressure on the phrenic in the cervical region produces respiratory disturbances.

Several Brazilian physicians have observed a diminution in visual and auditory acuity, probably on account of neuritis of the sensory nerves. The temperature of the body almost always remains normal, hyperthermia being very rarely observed. Convulsions of the muscles of the face are sometimes seen. Trembling of the limbs is exceptional.

When the beri-beri paralysis has existed a certain time, the electrical excitability of the muscles is weakened (Simonds).

The continuous current provokes only slow or sluggish contractions (Baelz). The induced current is without action unless strong. Finally, in the last stages the atrophied muscles do not react at all to electric excitation.

We have observed curious troubles of the memory in a European traveling in Colombia where he had contracted beri-beri in the following circumstances: He directed the exploitation of a gold mine in the woods. He was obliged to subsist like the natives almost exclusively on rice. An epidemic of beri-beri appeared among the personnel of the mine and attacked him at the same time. Neither malaria nor alcohol could be incriminated in this case. In addition to the signs of polyneuritis of the four limbs, the patient presented very clear symptoms of amnesia of fixation. He could not recall what had been said to him a few moments before. The memory of recollection was less affected. He did not have a blank amnesia, properly speaking, but a sort of dim amnesia, with which he was afflicted during his entire stay in Colombia. We treated this patient by re-education, tonics and hydrotherapy. In about two months, the cure was almost complete. Beri-beri amnesia would thus seem to be less grave than that following insolation.

**Mixed Beri-beri.**—This form, as its name indicates, includes all the symptoms found in the wet and the paralytic forms. The disease begins with edema and paralysis. In mixed beri-beri, pressure produces pain in the paralyzed muscles as in the atrophic form and the edema presents the variations which one observes in the wet form. The thoracic constrictions, the retro-sternal pains and the angina are intense in proportion to the severity of the attack.

**Complications.**—The complications which may be grafted upon beri-beri are those which are usually observed in all tropical diseases, that is, malaria, diarrhea and dysentery.

**Duration and Termination.**—Beri-beri is a disease of essentially variable duration. Rapidly fatal in the fulminant forms, it lingers through many months in the ordinary cases. It frequently leaves incurable paralysis in its wake and in almost all the jail hospitals there is a room where one may see several cripples, the debris of an epidemic of beri-beri.

Death from asphyxia may be seen during convalescence. The patient awakes from the midst of a siesta or in the middle of the night with a sudden dyspnea and intense constriction of the chest, the heart-beats are tumultuous and the patient emits a few groans and dies.

The wet form is more grave than the dry form, but the latter often leaves behind it incurable paralysis.



**Relapses and Reappearances.**—The relapses and reappearances are excessively frequent in beri-beri and a first attack of the disease is a predisposing cause for a second attack. One should therefore pay particular attention to the alimentation of the patient during convalescence and cure, if one does not wish to invite a relapse or a recrudescence.

Emigration is a good means of avoiding new attacks of the disease. In Japan one sees patients cured by leaving the endemic foci, but they relapse on returning.

**Diagnosis.**—Beri-beri should first be distinguished from other diseases by alimentation. Scorbutus has a symptomatology so entirely special that it is difficult to confound it with beri-beri. On certain ships one sees scorbutus and beri-beri developing side by side.

Lathyrism is, as we know, chronic poisoning caused by the ingestion of several species of vetch, vulgarly called the lathyrus (Spanish lentils, chickling-vetch, chick-pea, spurge-laurel, etc.). It is characterized by the existence of a spasmodic paralysis and the absence of edema.

As in all the spasmodic contractions, one observes in lathyrism exaggeration of the patellar reflexes and epileptoid tremors. There is no muscular atrophy. Finally, the toes are flexed and the point of the foot is somewhat rotated upon its internal border. In lathyrism the patient walks with the leg stiff in extension and the toes flexed so that they strike against rough places in the ground.

Pellagra is a disease due to the ingestion of damaged maize, which contains a toxic alkaloid, pellagrazine. Pellagra is characterized by the existence of erysipelatous plaques on the surface of the skin, covered with furfuraceous scales and studded with tubercles. Paralysis of the lower limbs and pellagic insanity are not observed long after the appearance of the erysipelatous plaques.

Chronic ergotism with contractures of the flexors of the limbs and dry gangrene is easily differentiated from the placid paralysis of beri-beri.

Chronic beri-beri has been often confounded with alcoholic polyneuritis, and many of the cases of paralysis supposedly due to beri-beri observed in Europeans are simply peripheral neuritis of alcoholic origin. Therefore one should always first think of chronic alcoholism in examining a case of peripheral neuritis observed in a white in the colonies. The interrogation of the patient permits one to assure himself that the case does not present the respiratory disturbances or the constriction of the thorax as is observed in the acute phase of kakke. In case one cannot determine habitual intemperance in a paralyzed European, one should direct his investigations to chronic malaria, which, as we know, is sometimes accompanied with peripheral neuritis. Finally, the diagnosis of beri-beri in the European may be assisted if it is known that he has been placed under the same conditions of alimentation as the natives.

Feris committed the error, excusable for the times, of confusing beri-beri with myxedema. This latter affection is so well known nowadays that this confusion is not possible. The hydropic form of beri-beri resembles the anasarca of acute nephritis, but beri-beri patients do not present albumin in the urine and the scrotum is not generally the seat of a serous infiltration.

**Prognosis.**—The appearance of certain symptoms in the patients forms an index of the gravity of the case. Dyspnea, accompanied by pericardial angina and rapid pulse, indicates a neuritis of the pneumogastric and should make one fear a fatal issue. Paralysis of the diaphragm indicates that the phrenic nerve is attacked. Hypothermia is usual in beriberics, but it does not fall below 36.5°C. A lower descent is a grave omen.

Francois has noted as a symptom of always fatal prognosis, the sensation of internal fire which the patient experiences. This is a forerunner of approaching death. The patellar reflexes are suppressed in acute beri-beri. Their reappearance announces a happy termination.

**Mortality.**—According to Le Roy and Mericourt, in Europeans, out of 215 patients 56 died, i. e., about one quarter. In the colored races, 2657 patients gave 885 deaths, i. e., about one-third. Beri-beri is therefore generally more grave in the colored races than in the white. Certain epidemics present a high mortality, 70 per cent in the epidemic of Bahia. Silva Lima, who made numerous statistics in the various forms of beri-beri, attributes a mortality of 78 per cent to the edematous form, 50 per cent to the paralytic form, 82 per cent to the mixed form. The minimum mortality which has been observed in certain epidemics of beri-beri does not fall below 15 per cent.

**Prophylaxis.**—The pathogeny of the affection indicates the prophylaxis of beri-beri. We have seen that it is only necessary to place natives attacked by an epidemic of beri-beri on a European diet to quickly arrest the disease. Beri-beri being thus attributable to an insufficiency or absence of certain principles in the ration, the first duty of the physician is to supply what is missing. The prophylaxis of beri-beri interests particularly physicians in charge of the various Indian, Annamite and Japanese emigrations, physicians serving with Hindustanee, Annamite, Tonkin, Sengalese, Sepoy and Malagash troops, and doctors in service in native jails and prisons.

We have placed first physicians in charge of emigrants because that type of native passengers depend upon the preventive measures which are taken by the captain of the ship from the viewpoint of alimentation (beri-beri) and drinking water (dysentery). Beri-beri should be expected if the food of the natives is composed exclusively of rice and salted fish. The best means of preventing the appearance of beri-beri is to add pork fat to the ration; to alternate the salted fish with salt pork and to issue, if possible, fresh pork or beef twice weekly. It is needless to add that ample provisions of onions, tamarinds, spice, peppers, salt and garlic should be provided.

**Treatment.**—(a) Dietetic. The first thing to be done is to place the patients on European fare. Maheo has remarked at the hospital of Choquan that the patients fed on the European ration recover much more rapidly than those remaining on the native food (Corre).

(b) Climato-therapy. The patient should be sent to the uplands, thus providing in a measure the advantages of a temperate climate. This measure is not always realizable. In this case the evacuation of the premises occupied by the beri-berics is sometimes sufficient to arrest the epidemic. On board ships the patients should be kept on deck as long as possible to avoid the disadvantages of the confined air below.

(c) Therapeutic. In the hydropic form diuretics should be given, nitrate of potassium, tincture of squills, or digitalis. The Brazilians use the Cainca root, which is prescribed in two forms, the decoction, 8 gms. in 300 cc. of water, or in powder gmm, 1.0 to 1.5 thrice daily.

Some physicians associate purgatives and diuretics, Walther recommending the following:

R  
Jalap or scammonium  
Powdered Squills  
Powdered Digitalis

aa gmm. 5.0

Make 100 pills.

Sig: Take one pill every two hours until pronounced effects.

Simmons has used with great success, jaborandi and pilocarpine. He reinforces with advantage this last medication with vapor baths given with the patient in his bed. He treats a failing pulse with caffeine.

Edema of the glottis necessitates tracheotomy.

In the paralytic form of beri-beri, the girdle pains may be relieved with aconite, belladonna, bromide of potassium or ergot to allay the spinal hyperemia. Friction and electricity may be used for the paralyses. One should use great care in the employment of strychnine in the treatment of beri-beri. The general tone should be raised with cinchona, kola, iron and arsenical preparations (Fowler's solution and Boudin's fluid). The latter are, moreover, of advantage in combating chronic malaria, often associated with beri-beri.

Counter irritation along the spinal column (actual cautery, blistering agents and tincture of iodine) have been employed by some physicians. The blisters are inconvenient in predisposing to bed sores. Iodine of potash is indicated in the chronic forms of the disease.

(d) Lumbar Puncture. We think that lumbar puncture or lumbo-sacral puncture would be of great service in the treatment of beri-beri. There are, in fact, distinct indications for active surgical intervention, the constant presence of a large quantity of serum in the spinal canal, constrictive pains of the thorax, dyspnea with angina, filiform pulse, etc. We advise the use of this operation, which is entirely harmless and is coming into general use.

#### SAN FRANCISCO COUNTY.

Paper by Dr. W. C. Voorsanger, "Aneurysm of the Left Ventricle."

Dr. D'Arcy Power, discussing: Undoubtedly cases of aneurysm of the heart are extremely rare, and I doubt whether it is possible to make a diagnosis except by most careful auscultation. Even with the radiograph I think that we shall not be able to do much. The same thing is true of aneurysms of the first part of the aorta. I have examined cases which have turned out to be aneurysm of the first part of the aorta in which there were neither physical signs nor symptoms. So far as aneurysm of the heart itself is concerned I think we shall always be in the same position, i. e., that the majority of cases will be diagnosed post mortem.

Dr. Cooper, discussing: Of late considerable advance has been made in chest radiography. We can now at a distance of six feet obtain a chest radiogram during suspended respiration, even in dyspneic people. Such a picture is practically an ortho-radiogram. The value of such work in the diagnosis of aneurysm of the heart depends upon whether the aneurysm makes a projection of the heart surface so as to throw an abnormal shadow outline either in the sagittal or coronal plane. If so, then radiography will probably be of much assistance.

Paper by C. G. Levison, "Intestinal Obstruction."

Dr. Barbat, discussing: The only thing that I can add in regard to these cases of obstruction which are due to hernia is that resection of the bowel should certainly be practiced if the patient has not been too thoroughly poisoned by waiting. I prefer making the resection with an end to end anastomosis, the Murphy button serving good purpose. The cases which the doctor did not speak of in his paper are the cases of adynamic ileus. Operation is practically of no avail. The disease has started outside of the intestine or it has arrived at the outside some time before being seen by a medical man or a surgeon, and these cases are particularly hopeless. In

cases of obstruction if seen early enough, I advise radical operation and not enterostomy. If the patient is poisoned and is in a serious septic condition, then enterostomy followed by radical operation is the correct surgery.

Dr. Schmoll, discussing: One cannot help being impressed by this appeal to the physician to refer cases for operation early. So far as the physician is concerned, only cases of ileus which occur in the slowly obstructing process can be considered as cases of strangulating ileus are referred to the surgeon right in the beginning. If we understand the paper correctly, Dr. Levison appeals to the physician to refer cases of slowly occurring obstruction at the stage when radical operation is possible. Under what condition can the physician diagnose these cases? The first symptom in such cases is constipation and I think it is a general mistake for the practitioner not to pay sufficient attention to the symptom complex of constipation. I confess that many errors of diagnosis I have committed have been due to the fact that I did not examine the patients with constipation sufficiently. Every case of constipation has to be gone into very thoroughly and I think every case in which constipation occurs after the age of 40 without any previous history of constipation is highly suspicious of beginning obstruction of the intestine. Very frequently I have seen in beginning carcinoma, periods of constipation alternated with periods of diarrhea, and in such cases one finds traces of blood or some pus in the diarrhetic stool; another point to which not sufficient attention is placed is the visible peristalsis. This occurs in almost every case if the patient is observed sufficiently. I remember a case which I have seen lately in which obstruction of the pylorus existed ten years. The diagnosis has not been made. I had to observe the case about a week until I saw visible peristalsis. Examination has to be extended for fifteen or twenty minutes and very frequently the visible peristalsis can be caused by tapping the suspicious place with a wet towel.

Dr. D'Arcy Power, discussing: The cases which puzzle the physician are those in which these typical symptoms are not met. Take, for example, the question of constipation occurring in patients after 40 years of age. Most females after this age are constipated, and yet it is the very age at which you get intestinal carcinoma. The old idea is wrong that carcinoma is associated with pain, cachexia and obstruction; in fact, so far as intestinal carcinoma is concerned, the great majority of cases are painless and cachexia is rarely present. I have in mind a case in which Dr. Terry and I were consultants. The patient had never been constipated or in any way sick or abnormal, but one day the normal defecation failed. There was no visible peristalsis, pain or distension, nor any marked toxemia or discomfort on the part of the patient. Purgatives and enemata gave no relief. On the fifth day when the abdomen was opened, we found complete obstruction of the transverse colon; it was absolutely blocked by a ring of carcinomatous tissue, yet there was nothing in the previous history or final development of the case which could have called attention to this condition. Thus there must always be a large number of these cases that never can be diagnosed until they are on the table, and then it is often too late.

Dr. Philip King Brown, discussing: One interesting thing in connection with this question of bowel obstruction is the remarkable contrasts that one sees in the cause of the obstruction. On the one hand, lymphosarcoma may almost fill the much-distended abdominal cavity, leaving scarcely a foot of the bowel uninvolved, and there will be no symptom of obstruction, while on the other hand a few strands of adhesions between the gall bladder and pylorus or duodenum, or between the bowel and the scar of a

hysterectomy, or in connection with a hernia, or following a diverticulitis, and one may find the most violent pain, and even a fatal obstruction. To the medical man, adhesions are vastly more commonly considered as a cause of complete or partial obstruction than anything else. Another point of extreme interest in this connection is the fact that these adhesions may exist many, many years without causing a single symptom, only to thrust themselves conspicuously into the foreground very suddenly, bringing about within a few hours conditions which threaten death. I regret to say that nearly every case that I have seen of acute obstruction due to adhesions has been operated on too late to give the patient the maximum chance of recovery. This has not always been any one's fault, for it is difficult sometimes to persuade even physicians of the extreme importance of early operation.

Dr. C. M. Cooper, discussing: In considering the diagnosis of intestinal obstruction we must bear in mind:

1. That diseases of the lung and pleura can by the irritation of the intercostal nerves, or by stimulation of the dorsal spinal segments, produce a condition strongly imitating an acute obstruction. The key to the situation lies in the disturbed respiratory pulse rhythm.
2. That in uremia the poisons produced may apparently paralyze the gut muscles, and hence the urine must always be investigated.
3. That the crises of locomotor ataxia may affect the intestine as well or independently of the stomach and so cause anomalous pictures.
4. That in lead poisoning such marked constipation may be present as to lead one astray if one does not systematically examine the gums for the blue line.
5. That auscultation of the abdomen is of considerable service, and we may conclude that if no murmur be heard for five minutes, obstruction is probably present.

I am glad Dr. Levison has called attention to the importance of thorough investigation of middle-aged people who come to us complaining of recently developed constipation and gas pains. In that investigation the sigmoidoscope is very serviceable, and if one will give the patient some charcoal about twenty-four hours previously to the sigmoidoscopic examination, oftentimes useful information relative to the passage of the food through the intestine to the rectum can be simultaneously obtained, and one can definitely determine that there is no obstruction higher up. The recent work of Hummel on the value of the X-Ray in the early diagnosis of these cases is so convincing as to speak for itself.

Dr. F. B. Carpenter, discussing: In the matter of operation, whether it should be radical, or whether one should content himself with enterostomy, depends greatly upon personal equation. It is evident to all of us that one man can do an operation very quickly, whereas another man fully realizes that he can not do the same operation in the same length of time; that man should be content with a temporary operation and subsequently do the secondary, whereas another man might do the complete operation at once. Another point of importance is that of stimulation for patients. Those of us who have watched the effects of interne work in the hospitals, and have left patients in charge of internes, have found invariably that the interne loaded the patients up with about everything he has learned in his college, and the consequence is that the patient who is prostrated by illness and appears very nearly dead is hindered in his progress by a load of strychnine or digitalis or any other stimulant. These things are not always adjusted by the chief, but the chief should keep them in mind.

Dr. Levison, closing: There have been several points discussed which have been incorporated in my paper. The first point mentioned was in reference to cachexia. All surgeons of experience have had patients come to them with inoperable carcinoma of the breast, uterus or intestines where cachexia was quite absent. This, consequently, should not be taken too seriously. Concerning visible peristalsis, I have on numerous occasions failed to see the peristaltic movements in bowel obstruction, because of the thick abdominal walls, even when the light has been most favorable; so that the bowel obstruction is not to be excluded when this sign is absent. The point mentioned by Dr. Bush, as to why the mortality should be 87% in enterostomy, performed for gangrenous hernia, and why it is 37% when the bowel is resected, is due in my opinion to the fact that resection is done early, before toxemia has developed, while enterostomy is performed in the last stage. This will account for the difference in the death rate.

Dr. Carpenter's statement in reference to stimulation I will answer by stating that the hypodermic syringe and saline infusion is practically unknown in my operating-room service, and it is due to the fact that my patient receives a very small quantity of anesthetic and is practically awake before leaving the table. My belief is that the surgical shock is not the result of the operation, but it is due to the excessive quantity of the anesthetic given. Post-operation nausea occurs but rarely in my service and I believe it to be also due to the fact that but a small quantity of ether is administered. The only indication to me for the employment of the saline infusion is where hemorrhage has occurred. Dr. Cooper brought up the point in regard to the blue line on the gums as a diagnostic point in lead poisoning. In my experience this is not pathognomic of lead poisoning. I have seen numerous cases of lead poisoning where the blue line on the gums was not present, and it is present principally with individuals who do not clean their teeth. The question of auscultation of the abdomen is very important. As I have stated, the position of the gurgling oftentimes makes it possible to locate the point of intestinal obstruction. In these cases the gas can be heard passing through the stenotic area.

#### SONOMA COUNTY.

Another fine meeting of Sonoma Medical Society chronicled. Dr. W. W. Kerr, of San Francisco, was heartily received, and he gave a lecture that all felt they could not have missed. The lecture will be published in full in the Journal. Dr. G. A. J. Scheuer was elected to membership.

After a fine chicken dinner the members autoed home, bringing with them Dr. Kerr, and arriving at Santa Rosa after midnight.

Ex-president Dr. J. W. Jesse has gone to attend the International Tuberculosis Congress, having been appointed by Governor Gillett a delegate.

G. W. MALLORY, Secretary.

#### SANTA CLARA COUNTY.

The regular Society meeting was held Sept. 16th in the Science Room of the new High School with the following members present: Drs. Jordan, Avery, Gallimore, Silvia, Hervey, W. S. Van Dalsem, Miller, Wagner, Smith, S. B. Van Dalsem, McGintl, Kapp, Hopkins, Simpson, Belknap, Kocher, Newell and Park. The visitors were Drs. Grant, Selfridge, Blake and Rucker of San Francisco, and Drs. Benepe, Bowen, La Breck, West and Wilson of San Jose. Three new members were admitted by application and one by transfer. Drs. H. B. Gates, Amelia Gates and D. R. Wilson by application and Dr. J. H. West by transfer from Contra Costa County.



Dr. Grant Selfridge read a short history on the subject of Bronchoscopy, as well as describing the instruments used. Lantern slides were used to show normal and pathological conditions met with in the use of the Bronchoscope. Drs. Selfridge, Blake and a nurse now prepared a patient for demonstrating the passing of the tube and after it was in place those present were given the opportunity of looking through the tube. Every one present greatly enjoyed Dr. Selfridge's paper and demonstration and we hope he will appear before this Society again.

Dr. Rucker of the M. H. S. gave a most interesting talk on "Plague as seen by the camera," using several dozen lantern slides to illustrate his remarks. As few of the physicians in this vicinity knew of the actual work done by the M. H. S. during the plague epidemic, the slides shown were of great interest, and if the applause given Dr. Rucker is any criterion, he and several hundred more slides will be given a royal welcome by this Society any time he can come here again.

K. C. PARK, Secretary.

#### ALAMEDA COUNTY.

The regular meeting of the Alameda County Medical Association was called to order at 8:45 p. m., President E. M. Keys in the chair. The minutes of the previous meeting were read and approved. Dr. A. Liliencrantz read a paper on "Fractures of the Skull," which was later followed by open discussion. The following resolution was indorsed unanimously by a standing vote:

Whereas, It has pleased Divine Providence to remove from our midst our esteemed colleague and brother, Dr. James P. Dunn, who by his professional attainments and skill, his service to public sanitation and his many good qualities of mind and heart have endeared him to his professional associates; therefore be it

Resolved, That we record our sense of loss at his untimely departure and extend our deepest sympathy to his bereaved family. Be it further resolved that a copy of these resolutions be forwarded to his widow.

Respectfully submitted,

DR. FRANK ADAMS,

DR. O. D. HAMLIN,

DR. H. G. THOMAS, Committee.

On the motion of Dr. H. G. Thomas a copy of the resolutions adopted by this society April 14, 1908, in regard to the plague situation, was ordered sent to the Board of Trade. Dr. E. N. Ewer read an official report of the plague situation, the work done, and present conditions, being the official report from the health office, signed by Dr. Long. The secretary read a letter from Dr. N. K. Foster, of Sacramento, endorsing our efforts in regard to the plague campaign.

Dr. A. Liliencrantz, synopsis of paper: Brain surgery is rapidly becoming a distinct specialty. Every surgeon, however, has a fair practical knowledge of what ought to be done in the ordinary injuries of the skull—2½ per cent of all fractures are of the skull. Don't always look for the classical symptoms, because these are likely to vary; you may have practically no symptoms beyond the history of an injury to the head. Don't expect to make an immediate diagnosis. Treat every case symptomatically until you are sure of diagnosis. In regard to the location of an injury to the brain, acute troubles are more difficult to locate than slow growths or chronic conditions. Differentiate between intra- and extra-dural troubles if you can. Lumbar puncture will often facilitate the diagnosis in regard to fracture. In severe injuries Cushing states that 90 per cent of those not operated on die, especially when confined to the base of the

skull, 60 per cent die within twenty-four hours. The modern method of making a large bone flap freely exposing considerable area of the brain surface and replacing the flap without any loss of bone, I think a very great improvement. It gives the operator a better chance to work. Don't forget that it is quite impossible to tell on which side the clot may be, it is well known that the hemorrhage may be on the same side as the motor symptoms.

The discussion was opened by Dr. R. T. Stratton, who stated that he believed the wide open incision indicated when necessary, but not as a regular procedure, sub-dural traumatism generally gives a higher temperature,—when in doubt always make a scalp incision and make a thorough examination of the skull. Drs. Bull, Adams, Porter and Buteau concluded the discussion. Dr. Buteau referred to a case that came under his care the fourth day after injury. The man had been beaten to unconsciousness by a gas-pipe thug, the lacerations in the scalp showed a dozen injuries, all of which were open and infected. A large scalp incision from the left temporal to the right posterior occipital region was made, and half the skull exposed, dissecting back the periosteum with the flap, the skull looked like a chicken board, the bones broken in small pieces, dirt and infection making their replacement impossible. Thirty-two square inches of bone were thrown away, ample drainage established, and the scalp replaced. The recovery was uneventful, patient regaining consciousness in two days. He attributed his success in this case, not to any special surgical skill, but to the radical measures adopted and the fact that the brain did not become infected.

During August 25th and 26th, Dr. Joseph Price of Philadelphia was a guest of this society. On August 25th a surgical clinic was held at the County Hospital; on the evening of August 26th a banquet was given in his honor at St. Marks, both of which were well attended.

The doctor proved himself a most genial guest; as well as a skillful surgeon, talking freely on all surgical questions; the clinic at the hospital included a perineal repair, vaginal hysterectomy and a laparotomy for pyosalpinx. One hundred and twenty-eight physicians were present, some forty automobiles being used.

Dr. Price congratulated Alameda County in having so many up-to-date hospitals and especially referred to our county institution, which was a first-class hospital and not an almshouse. He thought this institution far in advance of many of our eastern states. He thanked the society for the courtesies shown him and congratulated us on the harmony that seemed to prevail among the physicians here.

M. LEWIS EMERSON, Secretary.

#### CONCERNING THE ABBOTT ALKALOIDAL COMPANY.

"This Journal is in receipt of a letter, dated July 22, 1908, from Dr. W. C. Abbott, president of the Abbott Alkaloidal Company, which reads in part as follows: 'The good and welfare of the medical profession, as well as justice to ourselves, demand that we no longer remain silent in this matter of the continued unjust and absolutely unwarranted attacks being made upon us through the Journal of the American Medical Association by a coterie of people led by its editor who are using its pages for some ulterior purpose best known to themselves.' The writer then says that a pamphlet explaining his position is being forwarded to us, and continues: 'We bespeak for this presentation your most earnest attention. The interest of the profession you serve demands that you peruse it carefully and that you express your sentiments fully in your own publication.'

"We are glad of the opportunity to reply publicly to this letter, and desire to speak plainly and definitely on several points.

"In the first place, the American Medical Association has put the Abbott Alkaloidal Company under the ban, not in a spirit of animosity and unfairness, but that the medical profession of this country may be made aware of the true character of this company and its officers. In questioning this act of the American Medical Association it must be realized that this association is an organized body of 30,000 physicians, for the most part representative men and good citizens. Moreover, the work and policy of this association is entirely in the hands and under the control of its House of Delegates, which is a legislative body composed of physicians chosen by ballot in regular meetings of all the various state medical societies, which, with their component county societies, represent an organization of 75,000 physicians, or five-eighths of all the practitioners of the United States.

"A thorough investigation has been conducted into the affairs of the Abbott Alkaloidal Company, with the result of laying painfully bare its modern schemes of high finance, together with its methods of working the medical profession. The evident conclusions are: (1) That the president of the Abbott Alkaloidal Company has used, and is now using, his position as a member of the medical profession as a commercial asset; (2) That the company is publishing what purports to be a medical journal devoted to the medical sciences and to the interests of medical practitioners, but which, to all intents and purposes, is a house organ devoted to the interests of the company and to the advertising of its products; (3) That the president and vice-president of the company, though engaged in commercial lines, are members of medical societies and use this membership in medical meetings to advance the interests of their firm; (4) That the same officers, for the same reason, flood the reading pages of medical journals with so-called original articles, which are but thinly veiled advertisements, e. g., 48 articles by Dr. Abbott, who is not in active practice, appeared in various medical journals during 1907, almost all of which dealt with the treatment of different diseases; (5) That by glowing promises the company has induced physicians to become financially interested in its business and thus users and promoters of its products.

"The pamphlet, entitled 'An Appeal for a Square Deal,' alias 'Dr. Abbott's Reply to His Critics,' was duly received. This is a 48-page booklet with a full page frontispiece of Abbott in his shirt-sleeves, together with thirty-five pictures of the company's plant, from the sugar-coating to the circular-sending department, which have no direct bearing on the text. The reading matter varies in substance from an appealing whine to the heights of braggadocio. It certainly is not an argumentative document, and a careful perusal of its full contents serves in no way to convince the thoughtful reader that the charges of the American Medical Association were at all unfounded or exaggerated. In fact, the whole thing is a huge, palpable advertisement, and we can only express our sympathy for those who may be gullible enough to be at all taken in by it. Any possible show of dignity is absolutely lost by the all-pervading atmosphere of commercialism and Abbottism and the ever-present grasping out for the cash, e. g., 'The greatest bargain ever offered, a six months' subscription to the best medical journal published (American Journal of Clinical Medicine, nee Alkaloidal Clinic), a post-graduate course, a 300-page text-book of "active principle" therapeutics, and a 9-vial pocket case filled, all for one dollar.' Not for one moment does the man seem to be able to divorce himself from his dollar-getting schemes, either in his business, his literature, his journal or his personal defense.

"If any of our readers do not wish to accept the judgment of any man in this matter, let him ask himself and likewise answer the following question: 'What special virtue is to be found in Abbott, his company, his journal or his manufactured products, that can not be as well, or better, obtained elsewhere?' Several of these features have already received our comment, but what about his products and 'active principles'? Alkaloids, as pure as he can manufacture, are by no means rare or unique as remedial agents, and, furthermore, investigation by expert chemists has shown that many of his products are neither 'alkaloids' nor 'active principles,' while not a few of them are typical nostrums. In other words, anything of value that Abbott may place on the market can be readily secured from reputable drug houses, while there are already enough houses from which nostrums of all shades and varieties can be purchased. As has been pointed out, the Abbott Company is equipped to furnish not only the theory, the principles and the practice, but also the drugs for their application. It certainly would seem that a physician who in any way lends his support to the Abbott Company is nothing more than a penny-in-the-slot machine of which Abbott et al. hold the key.

"We have gone into this discussion in order to acquaint our readers with the facts as we see them, and in accord with our general endeavor to elevate the profession to which we belong, to make the M. D. of the physician stand for disinterested professionalism, to protect the doctor from the impositions of shrewd schemers, and to show that medical journals can succeed without endorsing the advertisements of fakes, nostrums and irregular business methods. It is very apparent that the editors of many medical publications are being 'worked' by the Abbott Company and that their official mouths are effectually sealed from uttering any words of protest by their acceptance of the Abbott advertisement.

"The burning question is, on which side should the physician and the medical journal stand? The middle ground is slippery and slants to the marshes and the mires."—The Old Dominion Journal of Medicine and Surgery, September, 1908, Richmond, Va.

#### UNIVERSITY OF CALIFORNIA HOSPITAL.

The University of California Hospital has been projected for some years, but the actual beginning of construction had been delayed owing to the difficulty of procuring the very large sum of money which was desired in order that the institution might start with a proper plant and an adequate endowment and that the Regents of the University and the faculty of the Medical Department might not have the burden of support upon them, as well as the task of management. These plans were, of course, necessarily abandoned at the time of the earthquake and the fire. But a step had been taken and that had been the removal of the first two years of the medical course from San Francisco to Berkeley, thus emptying all of the laboratories, recitation rooms, and lecture rooms occupied by the students of the first two years. Shortly after the earthquake, at a meeting of the faculty, it was decided that in view of the recognized difficulty of carrying the school without the hospital, and the now greater difficulty which was imposed by the crisis of the disaster, and also in view of the fact that hospital facilities were cryingly needed at that time in San Francisco, the faculty would undertake the task of raising money for equipping a part of the building for hospital purposes. In doing this, the original plan of having a fully endowed hospital which should be free to all of the poor of the State of California was regretfully abandoned, and it was decided that we would have a hospital similar to the other hospitals

in the city in which people should pay a per diem for their board, lodging and treatment, and that as soon as this had been established we would turn our attention to the securing of an endowment for the support of free beds on the basis of \$10,000 for a free bed to be maintained in perpetuity.

The first money was given by Mr. Evan S. Pillsbury from the Rockefeller Relief Fund, an amount of \$2000 which should be payable as soon as \$8000 more had been subscribed. As soon as this \$10,000 was obtained the work of remodeling certain parts of the building was begun, and the hospital was opened in April, 1907, with two wards of 15 beds each, and a maternity ward of ten beds, quarters for nurses and servants, operating room, laboratories, kitchen, dining rooms, etc.

In the summer of 1907 Mrs. William H. Crocker gave a second donation of \$2500 for the equipment of another ward of 20 beds, which had become much needed, due to the crowding of the smaller wards. There were, in addition, some private rooms provided, most of them furnished by the Hospital, one was furnished by Mrs. Max Schwabacher and one by Mrs. Harry M. Sherman. An x-ray plant was given by Mrs. Henry F. Allen. Various members of the faculty gave apparatus for laboratories and the operating room and ward services. In all the money given as such, for construction and other purposes, is on the following list:

#### Donors and Donations.

Raphael Weill .....	\$ 2,000.00
Rockefeller Relief Fund.....	2,000.00
J. J. Meyer.....	500.00
W. H. Bourn.....	250.00
Arthur Holland .....	50.00
W. H. Crocker.....	500.00
F. H. Buck.....	500.00
J. H. Hammond.....	500.00
Mrs. James Coffin.....	250.00
Mrs. Ethel W. Crocker.....	1,500.00
F. M. Smith.....	250.00
San Francisco Gas and Electric Co.....	1,000.00
Dr. Harry M. Sherman.....	500.00
Dr. Wallace I. Terry.....	500.00
Dr. Thomas W. Huntington.....	500.00
Dr. Herbert C. Moffitt.....	500.00
General Geo. Stone.....	500.00
New York National Exchange Bank Fund.....	500.00
McKillican Bros. Commission.....	224.77
Relief and Red Cross Funds.....	10,000.00
Raphael Weill .....	1,000.00
Mrs. Henry F. Allen.....	1,000.00
Henriette Lachman .....	500.00
Mrs. Wm. H. Crocker.....	2,500.00
Dr. A. A. D'Ancona.....	95.00
Massachusetts Relief Fund.....	100,000.00
Dr. Herbert C. Moffitt.....	20.00
Mrs. Jacob Roos (yearly subscription)....	12.00
Mrs. Elizabeth Roos (yearly subscription)...	12.00
Mrs. Gertrude S. Neustadter (yearly subscription) .....	12.00
Mrs. Max Schwabacker (yearly subscription) .....	12.00
Mr. Geo. H. Roos (yearly subscription)...	12.00
Dr. Wm. Watt Kerr.....	500.00
A. L. Lengfeld.....	5.00
J. N. Sresovich.....	8.50
Dr. D. W. Montgomery.....	500.00
Burt L. Davis.....	100.00
Adam Andrews .....	100.00

The hospital is at present fairly well equipped for any kind of medical, surgical or obstetrical cases; and it has treated, in the deferent services, nearly 1000 patients since it opened. About 150 babies have been born in the obstetrical service.

As regards endowment, Doctor P. K. Brown, in the summer of 1907, approached the members of the Massachusetts Committee for the Relief of San Fran-

cisco in Boston, and urged them to give to the hospital \$100,000 which was still in their hands, not then having been sent to the Relief Corporation of San Francisco. This gift was, with the consent of the Relief Corporation in San Francisco, and through them, paid to the hospital in the summer of 1908 and there are now established ten free beds in perpetuity named the Massachusetts Beds and these are filled by patients recommended by the Associated Charities of San Francisco, or designated by the Superintendent of the Hospital. Active efforts are in progress for the securing of a still larger endowment, and some endowments for single beds have already been promised.

It is the intention of the faculty to conduct this institution on the highest planes so that it shall be to the West, and especially to California, what the famous big hospitals of the East are there. It shall be owned by the people of the State, the title is vested in the Regents of the University, and the management is in the hands of the faculty of the Medical Department. It is a suitable object for the generosity of those who wish their gifts to live after them. It should be a monument to the endeavors of those who have been instrumental in its organization and support.

#### PUBLIC HEALTH AND CONSERVATION.

Prof. Irving Fisher, the eminent political economist of Yale University, who in one of his papers before the recent International Tuberculosis Congress in Washington declared that consumption costs the people of the United States more than a billion dollars a year, is preparing an exhaustive report for the National Conservation Commission, which will contain not only these figures but similar data on the economic loss to the country from all other preventable diseases.

Prof. Fisher is a member of the National Conservation Commission and for many years has been carrying on studies along these lines. The Commission received letters from physicians all over the country urging it to consider the bearing of public health on the economic efficiency of the nation in its efforts to ascertain the resources of the country.

The Commission from the beginning has contemplated reports on the economic aspects of several phases of the Conservation movement which affect the duration and effectiveness of human life, but Prof. Fisher has undertaken to prepare a comprehensive statements of the whole subject of the relations of public health to the general field of Conservation, and especially as to the waste from preventable diseases and unnecessary deaths.

Dr. Fisher is professor of political economy at Yale University and chairman of the "Committee of One Hundred" of the American Association for the Advancement of Science, which has for a long time been carrying on propaganda for the increase of national health through the elimination of preventable diseases. This Committee of One Hundred is composed of physicians and men engaged in active sociological work in every part of the country, and the results of their investigations and experience are all available to Dr. Fisher, so that his report ought to be the most thorough-going and complete summary of the situation ever made.

At the Tuberculosis Congress, Prof. Fisher declared that 138,000 persons die of consumption every year. The cost of medical attendance and the loss of earnings before death average at least \$2,400, he said, while if to this is added the money that might have been earned with health, the total loss in each case is about \$8,000. He pointed out, also, that the disease usually attacks young men and women just at the time when they are beginning to earn money and cuts off their earning power for about three years on an average, before they die.



This subject of the economic value to the country of a general raising of the average health came up in the Governors' Conference at the White House in May. Dr. George M. Kober, in his speech on the "Conservation of Life and Health by Improved Water Supply" at the Conference presented figures which showed that the decrease in the "vital assets" of the country through typhoid fever in a single year is more than \$350,000,000. Typhoid is spread by polluted water largely so that the death rate from this disease can be directly reduced by the purification of city drinking water. Dr. Kober quoted statistics to show that the increased value of the water to the city of Albany, where the typhoid fever rate was reduced from 104 in 100,000 to 26 by an efficient filtration plant, amounts to \$475,000 a year, of which \$350,000 may be considered a real increase to the vital assets of the city. Census Bureau figures show that the average annual death rate from typhoid in cities with contaminated water supplies was reduced from 69.4 per 100,000 to 19.8 by the substitution of pure supplies.

Dr. Kober cited estimates showing that the average length of human life in the sixteenth century was between 18 and 20 years, and that at the close of the eighteenth century it was a little more than 30, while to-day it is between 38 and 40; indeed, the span of life since 1880 has been lengthened about six years.

#### INFORMATION FOR MEDICAL STUDENTS.

##### From the Board of Medical Examiners.

Your careful attention is called to the requirements of the medical laws of California. Before an applicant can be permitted to take the examinations, he must present documentary evidence that he has graduated from a medical school, the requirements of which shall have been, at the time of granting such diploma, in no particular less than those prescribed by the Association of American Medical Colleges for that year.

The Association of American Medical Colleges requires, since 1905:

I. Before a student can enter upon his medical training, he must offer as a minimum requirement for admission, either:

(a) A Bachelor's Degree from an approved college or university; or

(b) A diploma from a university accredited high school, embracing not less than four years' study in the subjects required by the Association; or

(c) An examination in these subjects, as designated by the Association, totaling not less than thirty points;

(d) A certificate from examiners recognized by the State Board of Medical Examiners, viz: for Southern California, Miss Gertrude Henderson, Los Angeles; for San Francisco and vicinity, Prof. Harry Beal Torry, Berkeley.

II. A student may be allowed to enter on his medical work conditioned in not more than six points, but these conditions must be removed by satisfactory examinations before he is allowed to enter on the second year of his medical course. A student entering college with certificates other than those granted by the Board's recognized examiners, or entering upon his second year with matriculation conditions, is debarred for all time from taking the State Board examinations.

III. The curriculum of the medical school must include the subjects stated in the schedule of requirements of the Association of American Medical Colleges, and such subjects must be pursued the length of time therein stated.

Graduates in medicine have been refused the privilege of taking the examinations, because they had

not fulfilled the requirements of the Association. To prevent such a difficulty, your attention is particularly called to the requirements of the State law.

- A. Required, 16 points. Minimum.
- |  |          |
|--|----------|
| Mathematics (minimum, two years; maximum, three years), Algebra and Plain Geometry ..... | 4 Points |
| English (minimum, two years; maximum, four years) .....                                  | 4        |
| (a) English Grammar.   |          |
| (b) Rhetoric and Composition.  |          |
| Latin (minimum, two years; maximum, four years) .....                                    | 4        |
| (a) Latin Grammar.   |          |
| (b) Latin Prose Composition.   |          |
| (c) Reading four books of Caesar or equivalent.  |          |
| Physics (one year) with laboratory work .....  | 2        |
| History (one year), including Civics and Political Economy .....                         | 2        |
- B. Elective, 14 points.
- |  |   |
|--|---|
| English Language and Literature (two years). Only if taken after the required English .....      | 4 |
| Language—German, French, Spanish or Greek (four years). Not less than one year in any one .....  | 2 |
| Advanced Mathematics—Solid Geometry and Trigonometry (one-half year each) .....                  | 1 |
| Natural Science (one year), Biology (one year), or Botany and Zoology (one-half year each) ..... | 2 |
| Physical Science (one year), Chemistry.  | 2 |
| Earth Science—Physical Geography and Geology (one-half year each) .....                          | 1 |
| Physiology and Hygiene (one-half year)   | 1 |
| Astronomy (one-half year) .....  | 1 |
| Drawing (one-half year) .....  | 1 |

CHARLES L. TISDALE, M. D.,

Secretary, State Board of Medical Examiners,  
927 Butler Building,  
San Francisco.

#### ADDITIONS TO NEW AND NON-OFFICIAL REMEDIES.

To the list of articles accepted by the Council, which will appear in the Journal October 3, there have been added the following:

- Panase (F. Stearns & Co.).  
Panase Essence (F. Stearns & Co.).  
Panase Tablets (F. Stearns & Co.).  
Hemaboloids (Palisade Manufacturing Co.).  
Spirosal (Farbenfabriken of Elberfeld Co.).  
Gr. Eff. Bromide and Acetanilid Comp. (H. K. Mulford Co.).  
Gr. Eff. Caffeine and Sodium Comp. (H. K. Mulford Co.).  
Gr. Eff. Carlsbad Salt (Artificial) with Phenolphthalein (H. K. Mulford Co.).  
Adrin Sol. 1:500 (H. K. Mulford Co.).  
Adrin Tablets 1-65 gr. (H. K. Mulford Co.).  
Adrin Tablets 1-100 gr. (H. K. Mulford Co.).  
Adrin Tablets 1-200 gr. (H. K. Mulford Co.).  
Adrin and Cocaine Hydrochl. Tabl. (H. K. Mulford Co.).  
Adrin and Sparteine Sulphate (H. K. Mulford Co.).  
Adrin Ointment (H. K. Mulford Co.).  
Adrin Suppositories (H. K. Mulford Co.).  
Adrin Comp. Vaginal Suppos. (H. K. Mulford Co.).

From the former list, *Ichthyolum Austriacum* has been omitted, and at the request of the manufacturer the title "*Diabetin*" has been changed to "*Levulose*, Schering."

**BARRED FROM THE MAIL.**

Post Office, San Francisco, Cal. Office of the Postmaster, September 10, 1908.

To the Publishers of California State Journal of Medicine, San Francisco, Cal.

Gentlemen:—I beg to inform you that I am in receipt of communications from the Assistant Attorney General for the Post Office Department, informing me that the Postmaster General has declared un-mailable the advertisements of the hereinafter named parties as giving information where abortifacients may be procured or where criminal operations will be performed, in violation of Section 3893 of the Revised Statutes, as amended:

Mrs. Dr. Wagener, 2012 Folsom St.  
 Mrs. N. A. Reed, 1135 Turk St.  
 \*Dr. G. W. O'Donnell, 1720 Geary St.  
 Dr. Sylvester, 517 Twenty-third St., Oakland, Cal.  
 Dr. Rosen, 1269 Fourth Avenue.  
 Dr. Gunn, 1632 Ellis St.  
 Dr. James Neal, 1438 Ellis St.  
 Dr. King, 719 Van Ness Avenue.  
 Dr. E. E. West, 1115 McAllister St.  
 Mrs. Dr. Dwyer, 1438 Ellis St.  
 Mrs. Dr. Kohl, 1524 Webster St.  
 Mrs. Dr. Wyeth, 1524 Webster St.  
 Dr. West and Dr. West and Company, 1035 Golden Gate Avenue.  
 Dr. and Mrs. Davies, 824 Valencia St.  
 Mrs. Dr. Meyers, 2012 Folsom St.  
 Mrs. N. A. Rees, 1135 Turk St.  
 Dr. G. W. Olcott, 1720 Geary St.  
 \*Mrs. H. C. Edwards and H. B. Bright, 517 Twenty-third St., Oakland, Cal.  
 Dr. Page, 1438 Ellis St.  
 \*Dr. E. F. West, 1115 McAllister St.  
 Dr. J. Meal, 1438 Ellis St., Mrs. Dr. Lane, 1438 Ellis St., names assumed by Dr. J. Neal.  
 Mrs. Dr. Gwyer, 1115 McAllister St.  
 Mrs. Dr. White, 1524 Webster St.  
 Dr. Sims, 1035 Golden Gate Avenue.  
 \*Dr. W. H. Griswold, 894 Eddy St.  
 Dr. Leek and Davis and Dr. Leek & Company, 824 Valencia St.  
 Dr. Carpenter, 504 Haight St.  
 Dr. Boughton, 792 McAllister St.  
 Dr. Smith, 1620 Ellis St.  
 \*Dr. F. Thomas, 816 Turk St.  
 Mrs. De Cornelius, 701 Gough St.  
 Dr. C. C. O'Donnell, 912 Devisadero St.  
 The California Confinement Home, 2012 Folsom St.  
 Dr. Moore, 1720 Geary St.  
 Dr. C. C. Moore and Dr. G. W. Moore, 1025 Market St.  
 Dr. F. Kaner, 1438 Ellis St.  
 Dr. F. Gibson, 1438 Ellis St.  
 Dr. and Mrs. Maxwell and Mrs. Dr. Maxwell, 1524 Webster St.

You will please take notice that further copies of your paper offered for mailing at this office on and after September 14, 1908, containing any of these advertisements, will be refused.

Please acknowledge receipt of this letter.

Respectfully,  
 ARTHUR G. FISK, Postmaster.

[Note.—Names marked (\*) are to be found in the register of licensed physicians.]

**DR. A. W. HEWLETT GOES TO ANN ARBOR**

It may be true that "Westward the star of empire takes its way," but certainly it seems to be the case that Eastward many of our men find their way. Some of the foremost writers and journalists in the country have been drawn to the East from California,

and not a few of our physicians seem to follow the same fate. The latest desertion is that of Dr. Albion Walter Hewlett who has been chosen to fill the chair of Medicine at the University of Michigan, to take the place left vacant by Dr. Dock, who has gone to Tulane. Dr. Hewlett has contributed much to the progress of medicine in California and many of his articles have appeared in the State Journal. We certainly wish him every success in his new field of activity, and peace and happiness in his new home.

**PROFESSOR CHARLES MINER COOPER.**

It is a pleasure to announce that Dr. Cooper has been appointed Associate Professor of Medicine at Cooper College, San Francisco. We shall miss Dr. Hewlett, but the College will suffer no loss, as Dr. Cooper is so well qualified to carry on the teaching of medicine.

**SEPTIC RESEARCH.**

At the recent meeting of the San Joaquin Valley Medical Association, several physicians in attendance took occasion to inspect the sewage disposal plant of the City of Fresno. So keen was their interest that they all, with one accord, entered the septic tank and became intimately acquainted with new sewage. Dr. Ryfkogel reports the experience more exciting than interesting, but he says that after three hot baths and entirely new clothes, he could no longer smell himself. Be it known that the plank broke and thus added seven of our distinguished members to the contents of the sewage tank.

**PUBLICATIONS.**

**History of the Medical Society of the State of New York.** By James J. Walsh, M. D., Ph. D. Published by the Society, 1907.

**Second Report of the Wellcome Research Laboratories at the Gordon Memorial College, Khartoum.** Department of Education, Sudan Government, Khartoum.

**Progressive Medicine, Vol. III, September, 1908.** A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Octavo, 285 pages, with 30 engravings. Per annum, in four cloth-bound volumes, \$9.00; in paper binding, \$6.00, carriage paid to any address. Lea & Febiger, Publishers, Philadelphia and New York.

**Anatomy, Descriptive and Surgical.** By Henry Gray, F. R. S., late Lecturer on Anatomy at St. George's Hospital, London. New 17th American edition, enlarged and thoroughly revised, by J. Chalmers Da Costa, M. D., Professor of Surgery and Clinical Surgery, and Edward Anthony Spitzka, M. D., Professor of Anatomy in the Jefferson Medical College of Philadelphia. Imperial octavo, 1625 pages, with 1149 large and elaborate engravings. Price, with illustrations in colors, cloth, \$6.00, net; leather, \$7.00, net. Lea & Febiger, Publishers, Philadelphia and New York, 1908.

**Business Methods of Specialists, Or How the Advertising Doctor Succeeds.** By Jacob Dissinger Albright, M. D. Published by the Author, 3228 North Broad St., Philadelphia, Penn.

In a little book of one hundred and ten pages, the

author has managed to give a deal of information about an interesting class of our profession, for these sons of Belial are of our profession, as engaged in healing the sick with drugs and otherwise. The most interesting chapter in the book is the one entitled "The Advertising Specialist's Guarantee," in which the author describes the different documents of a financially reassuring nature, given by charlatans to their patients. It shows quite clearly that when two men enter into a contract the advantage lies with the man who has studied out his plan of action, and has had practical experience. The novice is at the mercy of the initiated.

Another thing pretty clearly demonstrated is that the advertising specialist has his troubles too, and that the regular practitioner, following along the beaten path of professional life, has probably much less worry, more honor, and almost always more remuneration than his more showy but erring brother. Now comes the question: Is it worth while to study charlatans with a view to copying any of their methods? It is not. Their ways are not our ways, and never can be, and that is the main reason for keeping aloof from them. Those therefore who would buy the book with a view to getting anything helpful to their practice out of it, will find a disparity between the amount of money expended and the practical benefits received.

D. M.

**Contributions to the Science of Medicine and Surgery by the Faculty in Celebration of the Twenty-fifth Anniversary—1882-1907—of the Founding of the New York Post-Graduate Medical School and Hospital, 1908.**

The 485 pages, to which the title of Contributions is given, contain 48 articles relating to medicine, surgery and allied branches. The great majority of said articles are faithful reproductions of the sterile short-cut methods which characterize the teaching offered the ticket purchasers at the New York Post-Graduate School. In the midst, however, of incomplete and useless case histories, a few points of interest may be gleaned. The recent graduate may read with profit the article by Beaumont Douglass, who enumerates at great length the disadvantages of post-graduate study in foreign lands where one "is in constant turmoil and confusion"; whilst "the real, earnest and enthusiastic work and development of technique can be done best in the post-graduate schools of the United States."

De Garmo's article on bladder wounds in hernia operations contains interesting data. Warren Plimpton's dissertation on the correction of deformities following Pott's fracture is well written and richly illustrated with appropriate radiograms.

In a brief article entitled "a reminder that fatal or serious results may follow operative treatment of buboes," Eugene Fuller reports several fatal cases illustrative of the dangers attending the use of the curette.

By far the best article of the entire volume is by one unconnected with the Post-Graduate School, Sidney Jacobson, who, in reporting the microscopic findings of a case of true primary ovarian pregnancy, makes a most thorough review of the literature of the subject.

**Nursing the Insane.** By Clara Barrus, M. D., Woman Assistant in the Middletown State Homeopathic Hospital, New York. The Macmillan Company, New York, 1908.

Institutions for the insane have within the last decade undergone striking and important changes. For years merely regarded as places of detention and custody, they have evolved into modern hospitals, which aim to provide, not only comfortable and hygienic surroundings, but scientific treatment directed to the amelioration and sometimes the cure of the mental conditions. The advances made in handling

insane patients lie largely in the perfecting of the nursing; and that the training of nurses and attendants for this class of patients covers a much wider field than that of the ordinary trained nurse is quite evident. "She must safeguard them from injuring themselves or others, must possess many of the qualities that make a good teacher, since a part of her duty is to help correct faults in early training and development, and to encourage and train to correct and useful and proper behavior; she has also to employ and entertain her patients, under the direction of the medical officers; and to her is entrusted that almost constant association and companionship which, if sympathetic and judicious, is one of the most potent means of restoring her charges to mental health." It has, therefore, been apparent to those connected with the administration of insane asylums, that a text-book containing the essential points of such nursing has long been desirable. In this book we find the special instructions required, together with naturally the essentials of ordinary nursing. We unhesitatingly recommend the perusal of it to all classes of nurses, as well as physicians in touch with insane patients.

A. J. L.

### DEATH OF MRS. WILLS.

The death is announced at Los Angeles of Mrs. Charlotte Le Moyne Wills, mother of Dr. Wm. Le Moyne Wills, who was for many years one of the best known residents of Los Angeles; prominent there in philanthropy, as a woman suffragist, and as one of the founders of the Friday Morning Club. Mrs. Wills was the daughter of Dr. Julius Le Moyne, who introduced cremation into the United States, he having built the first crematory in this country in 1876, at Washington, Pennsylvania. Mrs. Wills shared the views of her father and was instrumental in having built in Los Angeles the Rosedale Crematory, which was constructed in 1887. Until age and illness practically confined her to her home, Mrs. Wills was actively engaged in the social and philanthropic work for which she was noted, and few medical men of California have been to Los Angeles without meeting her. But few of them probably knew that, by her successful advocacy of cremation, she was a practical coworker of theirs in sanitation.

### CHANGE OF ADDRESS.

Parsons, E. W., from 2580 Mission st., to 2597 Mission st., San Francisco.

Wemple, Emmett L. R., from 1059 O'Farrell st., to 240 Stockton st., (Schroth Bldg.) San Francisco.

Salomon, Max, from 1059 O'Farrell st., to 240 Stockton st., (Schroth Bldg.) San Francisco.

Weis, Arthur H., from 1546 Ellis to 16th and Mission, San Francisco.

Frederick, M. W., from 2152 Sutter to 135 Stockton st., (Butler Bldg.) San Francisco.

Horstmann, E. H., from Los Angeles to German Hospital, San Francisco.

McCarthy, Isaac A., from Union Trust Bldg., Los Angeles, to 1264 W. Adam st., Los Angeles.

Bock, Chas., from 703½ Central ave., Los Angeles, to Palms Springs Sta., Riverside County, Cal.

Avery, Ralph W., from 1005 Fair Oaks ave., So. Pasadena, to Alexander Bldg., So. Pasadena.

Griffin, Chas. Francis, from 3144 24th st., to 2804 Folsom st., S. F.

Watt, Fred W., from Pinogrande, El Dorado Co., to Morgan Hill, Santa Clara Co., Cal.

Baker, Clarence C., from 2186 Bush st., to 1028 Market st., San Francisco.

Titchworth, Jas. C., from 2980 Bush st., to Sherwood, Cal.



**French, J. Rollin**, from 526 St. Louis st., Los Angeles, to Spinks Bldg., 5th and Hill sts., Los Angeles, Cal.

**Hindman, S. J.**, from Moneta and Slauson aves., to 55 Moneta ave., Los Angeles.

**Allen, Chas. Lewis**, from San Fernando Bldg., Los Angeles, to Pacific Electric Bldg., Los Angeles.

**Dudley, Wm. H.**, from H. W. Hellman Bldg., Los Angeles, to Pacific Mutual Ins. Bldg., Los Angeles, Cal.

**Moore, Will H.**, from San Diego, Cal., to Sykeston, North Dakota.

**Pope, Fred'k S.**, of San Jose, Cal., traveling abroad.

**Gedney, Fred'k M.**, from 1696 Sutter st., to 304 Clement st., San Francisco.

**Wright, Fred'k L.**, from 1169 Broadway, Oakland, to 1155 Broadway, Oakland.

**Smith, Dudley A.**, from 1111 Washington st., Oakland, to Union Sav. Bank Bldg., Oakland, Cal.

**Liliencrantz, A.**, from 359 Telegraph ave., Oakland, to First Nat'l Bank Bldg., Oakland, Cal.

**Irwin, W. H.**, from Macdonough Bldg., to First National Bank Bldg., Oakland.

**Hadden, David**, from 2716 Telegraph ave., Oakland, to Wright Bldg., Berkeley, Cal.

**Hector, Robert**, from 1908 Shattuck ave., Berkeley, to Wright Bldg., Berkeley.

**Reinstein, Arthur H.**, from 2597 Sacramento st., San Francisco, to Veterans' Home, Napa, Cal.

**Rice, Weston H.**, from 577 Telegraph ave., to 229 Telegraph ave., Oakland, Cal.

**Sutherland, Hester M.**, from 2605 Ashby ave., Berkeley, to Fabiola Hospital, Oakland, Cal.

**Carlson, Chas. H.**, from 1823 Geary st., to Union Square Bldg., 350 Post st.

**Mace, Lewis S.**, from 1059 O'Farrell st., to Schroth Bldg., 240 Stockton Bldg., San Francisco.

**Chipman, Ernest**, from 2400 Pacific ave., to Schroth Bldg., 240 Stockton st., San Francisco.

**Minaker, Andrew J.**, from 1278 Market st., to 146 Grant ave., California Optical Bldg., San Francisco.

**West, Jacob H.**, from Black Diamond, Cal., to Bank of San Jose Bldg., San Jose, Cal.

**Arbogast, J. L.**, from St. Helena, Cal., to 719½ K st., Sacramento, Cal.

**Bennett, Laura B.**, from San Pedro, Cal., to Wright & Callender Bldg., Los Angeles, Cal.

**Kress, Geo. H.**, from the Johnson Bldg., Los Angeles, to Bradbury Bldg., Los Angeles.

**Chapline, Frank L.**, from Los Angeles, to Orange, Cal.

**Roth, Leon J.**, abroad for a year.

**E. Myrtle Wellcome-de Blois**, from 1329 So. Grand ave., Los Angeles, Cal., to Brawley, Imperial Co., Cal.

**Powers, Geo. H.**, from 1214 Polk st., to 111 Ellis st., (Powell Bldg.) San Francisco.

**Hoffman, Lawrence H.**, from 3014 Washington st., to Butler Bldg., (135 Stockton st.) San Francisco, Cal.

**Baker, Wood C.**, from address unknown, to San Mateo, Cal.

**Beasley, M. E.**, from address unknown to Vista Grande, San Mateo Co., Cal.

**Schulze, Otto T.**, from U. C. Hospital, San Francisco, to Veterans' Home, Napa, Cal.

**Bulson, Chas. H.**, from Ochener Bldg., Sacramento, to Veterans' Home, Napa, Cal.

**Duncan, Franklin T.**, from Sutter and Webster sts., San Francisco, to 1353 Broadway, Oakland.

**Mauzy, Wm. Peter**, from 654 14th st., Oakland, to 570 Williams st., Oakland.

**Morse, Fred W.**, from 1204 Harrison st., Oakland, Cal., to Oakland Sav. Bank Bldg., Oakland.

**Northcott, E.**, from 3028 E. 17th st., to 3116 E. 14th, Oakland.

**Bishop, Simeon** from address unknown, to 3rd ave., and Clement sts., San Francisco, Cal.

**Deane, Tenison** from address unknown, to Ukiah, Cal.

**Freedman, Chas.**, from address unknown, to Redondo, Cal.

**Gardner, J. F.**, from address unknown, to 1204 Railroad ave., San Francisco.

**Grissim, Jno. De L.**, from address unknown, to 1111 Washington st., Oakland, Cal.

**McCue, Jas. E.**, from address unknown, to Central Bank Bldg., Oakland, Cal.

**Owen, G. R.**, from address unknown, to San Bernardino, Cal.

**Pyle, F. S.**, from address unknown, to Valencia and 22d st., San Francisco, Cal.

**Powell, Thomas**, from southwest corner 8th and Hope sts., Los Angeles, to Columbia Trust Co. Bldg., Los Angeles, Cal.

**Mosher, Clelia Duel**, from 1100 Bryanti st., Palo Alto, to 1094 Emerson st., Palo Alto, Cal.

**Day, Robert V.**, from Bradbury Blk., Los Angeles, to Lissner Bldg., Los Angeles, Cal.

**Creamer, M. S.**, from 3146 Vermont st., Los Angeles, to 501 Homer-Laughlin Blk., Los Angeles.

**Stafford, Owen R.**, from 4206 Vermont ave., Los Angeles, to 3754 Vermont ave., Los Angeles, Cal.

**Spalding, Alfred Baker**, from 2510 Washington st., San Francisco, to 240 Stockton st., (Schroth Bldg.) San Francisco.

#### New Members.

**Scheuer, G. A. J.**, Guerneville, Cal.

**Force, J. N.**, 3223 College avenue, Berkeley, Cal.

**Bingaman, Elmer W.**, Soledad, Cal.

**Reynolds, Geo. E.**, Haywards, Cal.

**Smith, Arthur M.**, 876 Adeline St., Oakland, Cal.

**Mays, Wm. H.**, First Nat'l Bank Bldg., Oakland, Cal.

**Grissim, Jno. De L.**, 1111 Washington St., Oakland, Cal.

**Bixby, W. E.**, Union Sav. Bank Bldg., Oakland, Cal.

**McClurg, Katherine**, Union Sav. Bank Bldg., Oakland, Cal.

**Stone, Earl A.**, 1111 Washington st., Oakland, Cal.

**Maston, B. B.**, First Nat'l Bank Bldg., Oakland, Cal.

**Benton, Julian J.**, 2108 Shattuck ave., (Shattuck Bldg.) Berkeley.

**Dietz, Henry Louis**, 1630 8th st., Oakland, Cal.

**Duncan, Franklin T.**, 1353 Broadway, Oakland.

**Pardee, Geo. C.**, Oakland Sav. Bank Bldg., Oakland.

**Prather, D. J.**, 1219 Broadway, Oakland.

**Browning, Fred'k W.**, Haywards, Cal.

**Medros, Joseph J.**, Haywards.

**Gates, H. B.**, San Jose, Cal.

**Gates, Amelia L.**, San Jose, Cal.

**Wilson, D. R.**, San Jose, Cal.

**Wintermute, Geo. Preston**, Oakland, Cal.

**Beetle, Clarence Hollman**, Berkeley, Cal.

#### Deaths.

San Francisco Co.—S. R. Mather.

San Francisco Co.—Herman F. Maleck.

Los Angeles Co.—Orlando T. Pratt.

Alameda Co.—Cyrus Hamilton Allen.

San Diego Co.—George T. Greenleaf, formerly of

Redlands, Cal., died in Holtville, Cal.

San Diego Co.—Thos. K. Smith of La Jolla, Cal.

Los Angeles Co.—David M. Goodwin, Los Angeles, Cal.

Los Angeles Co.—Lloyd G. VanScoyoc, Los Angeles, Cal.

San Francisco Co.—Walter F. Percival, San Francisco.

Amador Co.—Benj. T. Freshman, Amador City, Cal.